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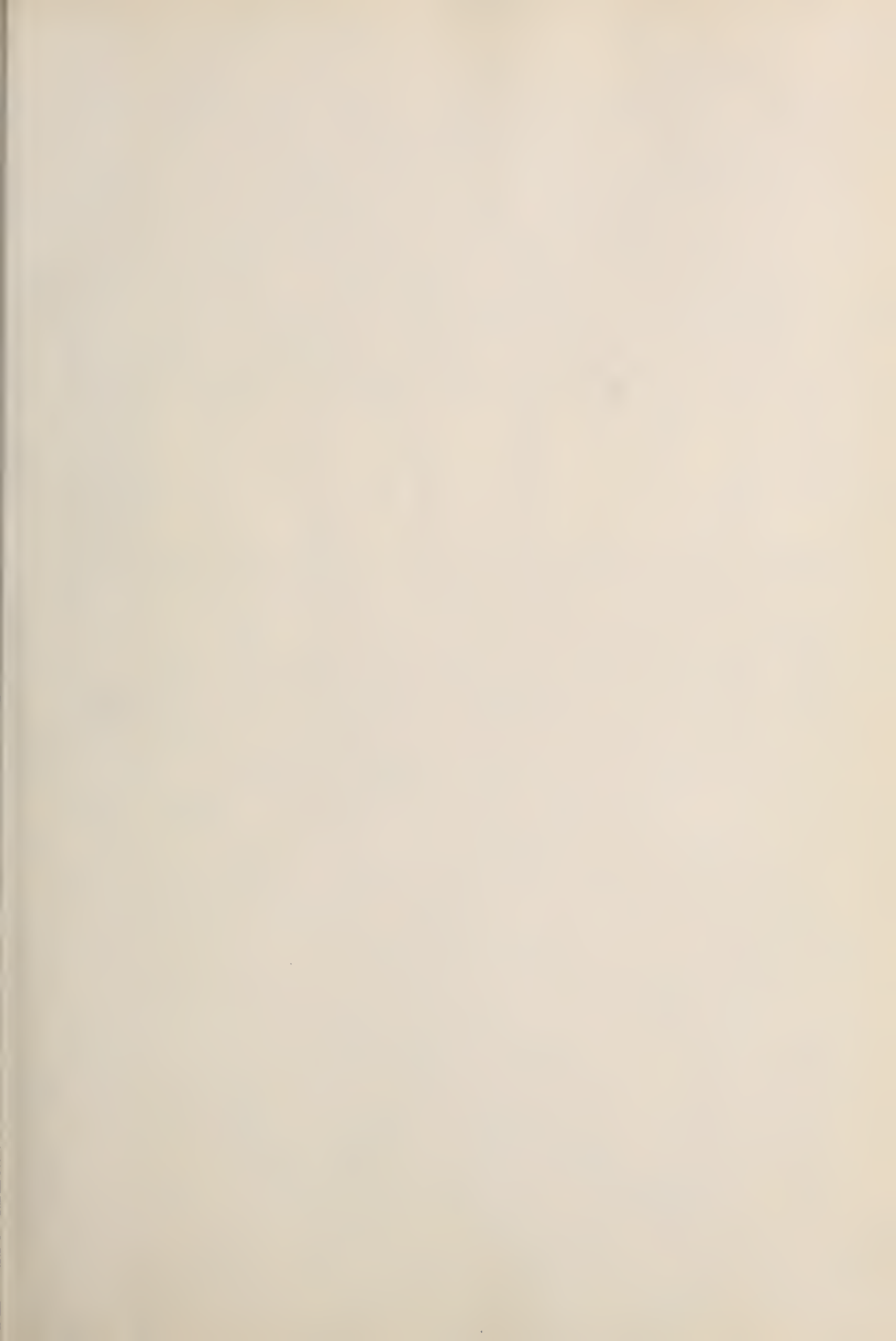
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JULY, 1966

Volume 53

Number 7

BALCONY

The **JOURNAL**
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Proceedings Issue

92nd Annual Meeting – Hollywood

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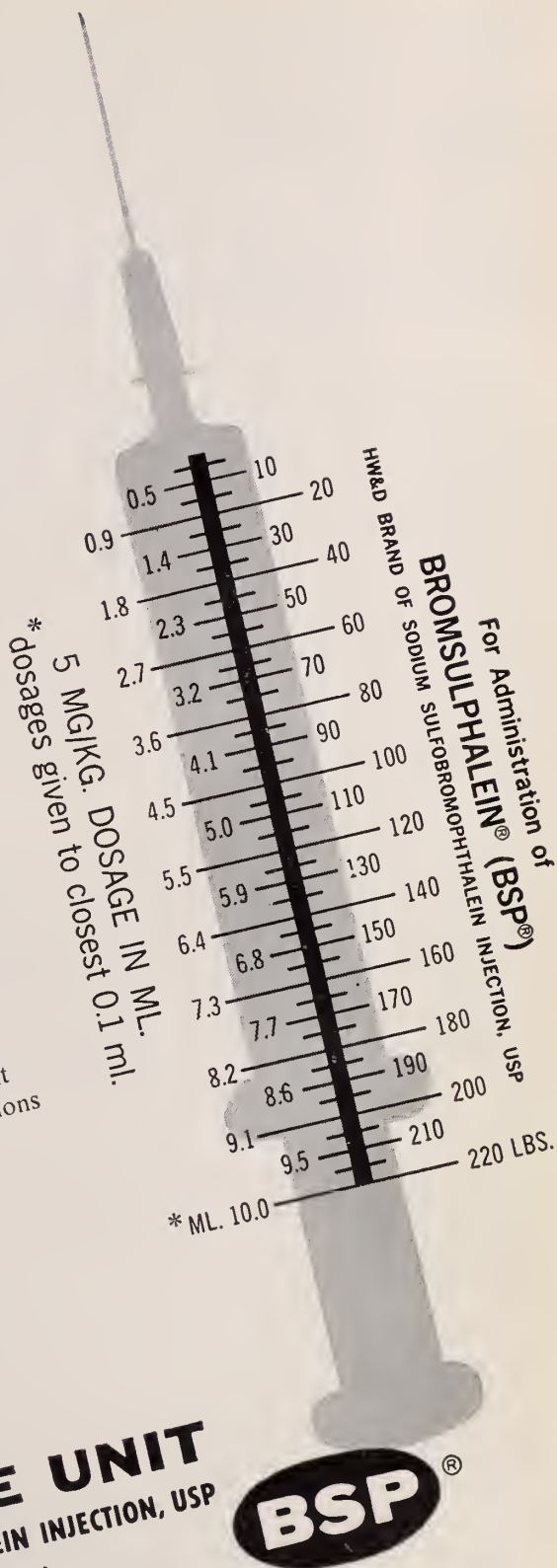
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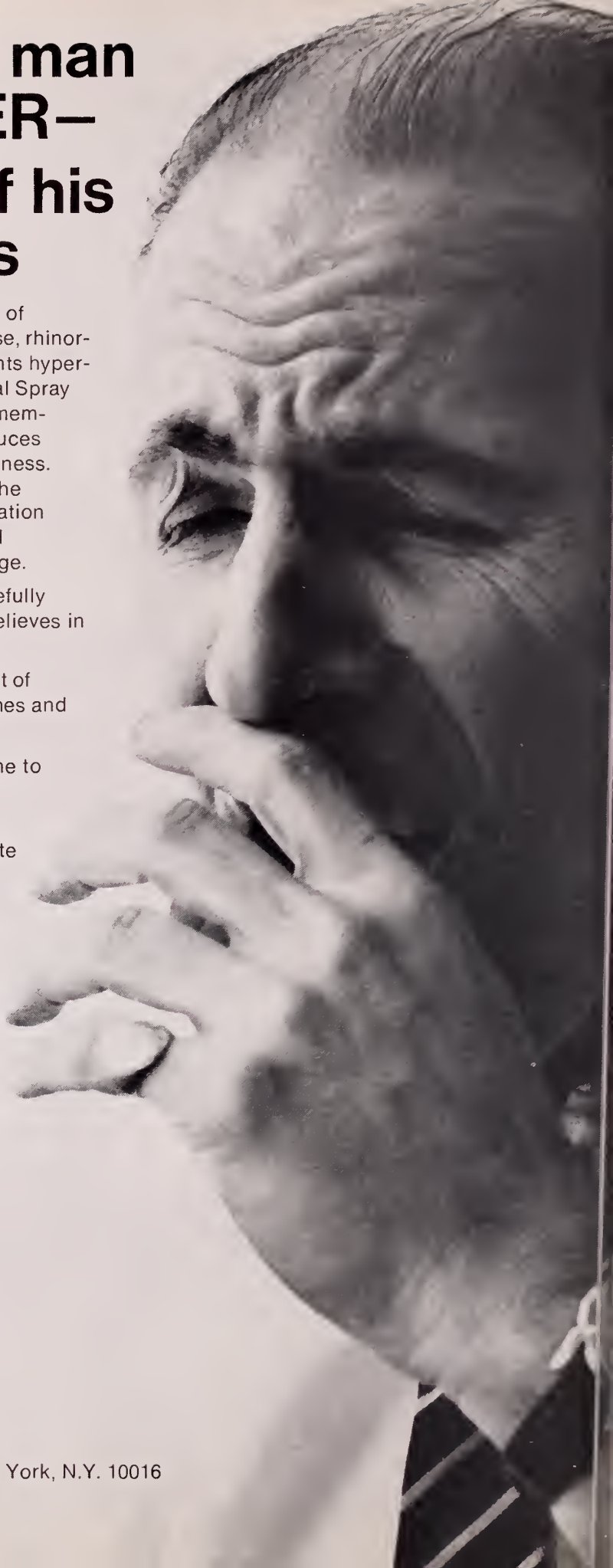
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Volume 53, Number 7, July 1966

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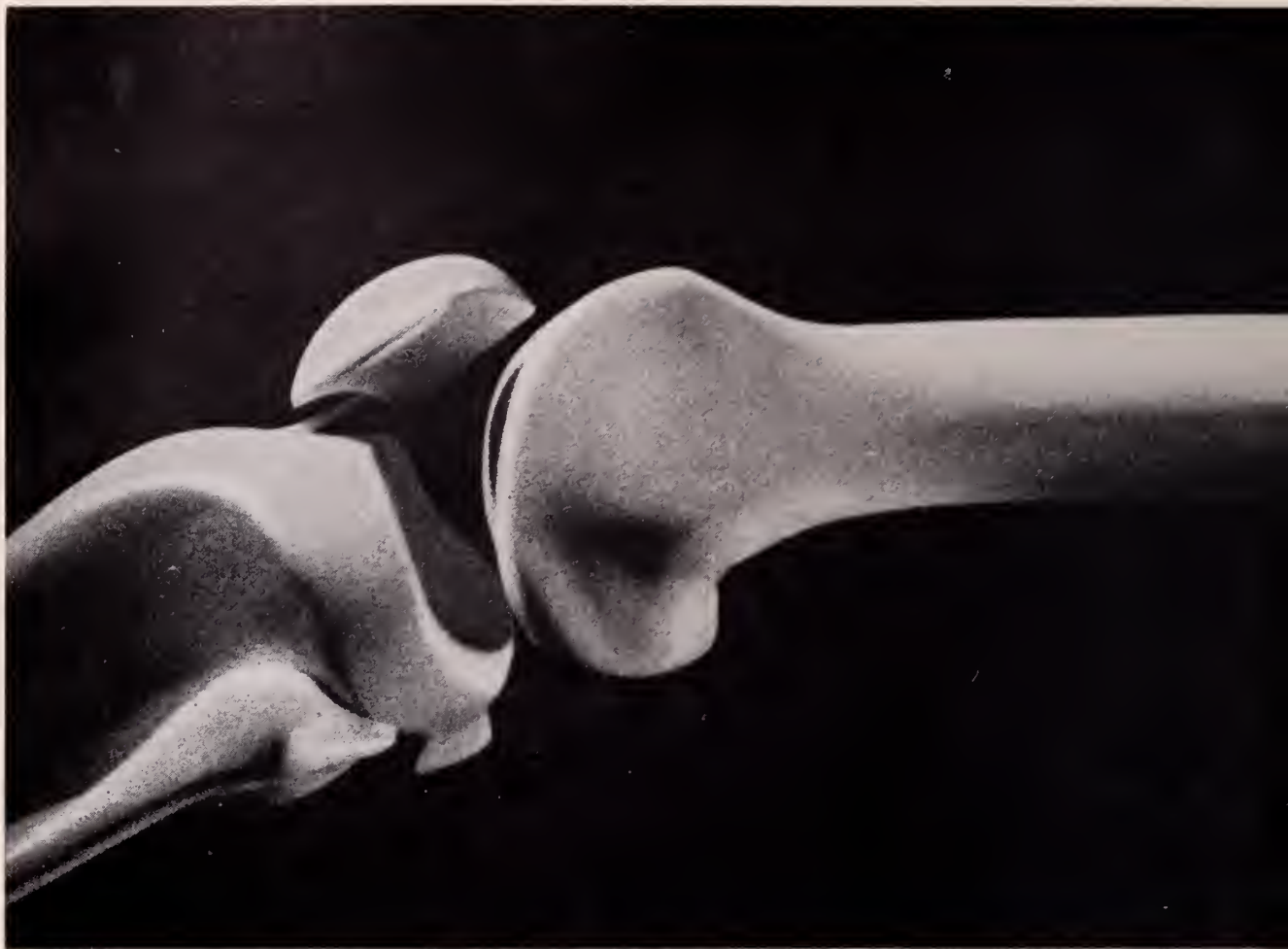
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Precautions

Obtain a detailed history and a complete physical and laboratory examination, includ-

ing a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Make regular blood counts. Use greater care in the elderly.

Warning

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The most common are nausea, edema and drug rash. Hemodilution may cause moderate fall in red cell count. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss

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References: 1. Editorial: *JAMA* 191:592 (Feb. 15) 1965. 2. Meilman, E., in Moyer, J.H.: *Hypertension*, Philadelphia, W.B. Saunders Company, 1959, p. 395.

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Contraindications: Salutensin is contraindicated in severe depression.

Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss, which may cause digitalis intoxication, responds to potassium-rich foods, potassium chloride or, if necessary, stopping therapy. Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy two weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution with patients with peptic ulcers or renal insufficiency (if severe, Salutensin is contraindicated).

Side Effects: *Hydroflumethiazide:* Purpura plus or minus thrombocytopenia, hyperuricemia, leukopenia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)

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Precautions: 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

Side Effects: The only side effect reported with frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. (Rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, gastrointestinal symptoms.)

One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, and an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reaction to carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

Dosage: Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

Supplied: Two Strengths: 350 mg. white tablets and 250 mg. orange, two-piece capsules.

Before prescribing, consult package circular.

**for the relief
of low back
sprains and strains**

SOMA
(CARISOPRODOLO)



Wallace Laboratories, Cranbury, NJ

PENTID®-SULFAS FOR SYRUP

SQUIBB BUFFERED PENICILLIN POWDER WITH SULFADIAZINE, SULFAMETHAZINE, AND SULFAMERAZINE

the fruit punch
that packs a wallop



Pentid-Sulfas for Syrup is a real knock-out when it comes to good taste. And, with a single prescription, you provide an anti-infective that combats both gram-positive and gram-negative bacteria. Notable for its economy, Pentid-Sulfas for Syrup is everybody's choice, patient, parent and physician.

Contraindications: Contraindicated in patients sensitive to sulfa or penicillin, pregnant females at term, premature infants, newborns during first week of life. **Precautions:** Watch for hypersensitivity reactions and overgrowth of nonsusceptible organisms. Observe usual precautions for sulfonamide therapy; adequate fluid intake; force fluids if urine volume is low; maintain urinary pH of 7 or higher; use only after critical appraisal in patients with liver or renal damage, urinary obstruction, blood dyscrasias. **Adverse Reactions:** Anaphylactoid

shock (rare), G.I. disturbances, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, urticaria, purpura, hematuria, crystalluria, conjunctival and scleral varicula, petechiae may occur. **Dosage:** Daily pediatric dosage should supply 65-100 mg. trisulfapyrimidines per pound body weight in divided doses q. 4 to 6 h. **Supply:** Pentid-Sulfas for Syrup when prepared, provides 80 cc. (16 doses) or 150 cc. (30 doses) of fruit-flavored syrup providing in each 5 cc. teaspoonful 125 mg. (200,000 u.) potassium penicillin G and 167 mg. each of sulfadiazine, sulfamethazine, and sulfamerazine.

Now . . . **NEW PENTID® '400'-SULFAS FOR SYRUP** (buffered penicillin powder with sulfadiazine, sulfamethazine, and sulfamerazine each 5 cc. providing 250 mg. [400,000 units] potassium penicillin G and 167 mg. each of sulfadiazine, sulfamethazine, and sulfamerazine). Available in 16-dose (80 cc.) and 30-dose (150 cc.) bottles.

For full information, see Product Brief.

SQUIBB



Squibb Quality—the Priceless Ingredient





for Herbert! It's good to see you get away from the office.

That reminds me. Remember those sinus pills I've been taking?

all you can do for the patient out here is let him lay through. But when he comes up again Monday morning, I can usually give him the relief he's looking for with Novahistine Singlet.

Each single tablet provides prompt anesthetic effect for relief of sinus pain. Then Novahistine Singlet also attacks the underlying cause of the headache—helps to open blocked respiratory

passages and restore normal sinus drainage. The continuous decongestant effect produced by one Novahistine Singlet every 8 hours helps reduce the chance of acute sinusitis progressing to chronic stages.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution your ambulatory patients that Novahistine may occasionally cause

drowsiness. Each tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.

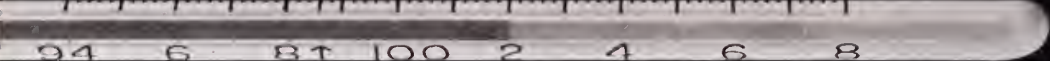
NOVAHISTINE[®] SINGLET^(TM)

For relief of sinusitis pain and congestion.



PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis

good reason
to select
Ilosone[®]
Erythromycin Estolate
for bacterial
infections



two to four times
the therapeutic
activity of other
erythromycins

CONTRAINDICATIONS: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

SIDE-EFFECTS: Even though Ilosone is the most active oral form of erythromycin, the incidence of side-effects is low. Infrequent cases of drug idiosyncrasy, manifested by a form of intrahepatic cholestatic jaundice, have been reported. There have been no known fatal or definite residual effects. Gastro-intestinal disturbances not associated with hepatic effects are observed in a small proportion of patients as a result of a local stimulating action of Ilosone on the alimentary tract. Although allergic manifestations are uncommon with the use of erythromycin, there have been occasional reports of urticaria, skin eruptions, and, on rare occasions, anaphylaxis.

DOSAGE: *Children under 25 pounds*—5 mg. per pound of body weight every six hours. *Children 25 to 50 pounds*—125 mg. every six hours. *Adults and children over 50 pounds*—250 mg. every six hours. For severe infections, these dosages may be doubled.

Available in Pulvules[®], suspension, drops, and chewable tablets. Ilosone Chewable tablets should be chewed or crushed and swallowed with water.

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.



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The JOURNAL *of the Florida Medical Association*

President's Address

H. Phillip Hampton, M.D., Tampa

Adaptation, Fortitude and Intelligence

The annual addresses of previous medical association presidents have ranged in subject from descriptions of epidemics and pointing with pride to medical advances, to predictions of things to come both good and bad. All have sought the truth in pressing problems of the day.

The twenty-fifth president of the American Medical Association about 100 years ago was concerned with the pressing "epidemic" of his day, "the woman question," and stated in his address:

Women may possibly become persuasive preachers, or even safe practitioners of domestic medicine; but learned and subtle divines, great lawyers, scientific physicians—never. To reach such eminence, a knowledge of principles is necessary, a power of eliminating the essential from the accidental, of distinguishing plausible falsehood from genuine truth, and that power has been denied them. . . .

On the whole, then, we believe that all experience teaches that woman is characterized by a combination of distinctive qualities, of which the most striking are uncertainty of rational judgement, capriciousness of sentiment, fickleness of purpose, and indecision of action, which totally unfit her for professional pursuits.

If, then, woman is unfitted by nature to become a physician, we should, when we oppose her pretensions, be acquitted of any malicious or even unkindly spirit. We may admit that she is in some sense a perfected man, and was created a little less lower than the angels; we may admit that guided by her affections, her judgements sometimes resemble inspirations; but in the business of life, and especially in the practice of a scientific art, it nevertheless may be true, and probably is so, that she usually displays a strange ignorance of the logic of reason, and a profound contempt for the logic of facts.

In the 100 years following these predictions, women have fared well, and many have become scientific physicians. The new environment has been good to them, and now they live 10% longer than the male, have 55% of the vote and control 85% of the wealth in this country. Indeed in the coming cybernetic age their fitness to survive may be further enhanced by their "profound contempt for the logic of facts," confounding the computers and escaping electronic regimentation which threatens the male.



Dr. H. Phillip Hampton delivers his President's Address to the House of Delegates.

The changing environment is accelerated by development of new knowledge. Existing institutions react and must adapt or perish to the inevitable advance of science. For instance, the steam engine knocked the feudal system into a cocked hat and new systems of government were developed to deal with problems of industrialization and urbanization including the resulting masses of poverty. The "Poor Laws" of Elizabeth I established government responsibility "to provide for those who have call upon the aid and sympathy of society by reason of age, infirmity or misfortune," and that has been the states' constitutional obligation since the beginning of our country. Because of the failure of state government to provide adequately medical care for those in need, we now witness federal assumption of responsibility to give personal medical services as a right of citizenship.

In recent decades man has acquired new knowledge and achieved advances in medical care as important as any recorded, and in the amount previously requiring centuries to develop. There has consequently been great increase in the demand and expenditures for medical care.

It is small wonder, then, that the systems of medical care are in a state of revolution. The little black bag can no longer contain the armamentarium needed for modern medical care and the individual physician can no longer be effective as the single paragon of medicine in his domain. Modern medical care requires the cooperation of physicians and the institutionalization of equipment. We must beware of the inference that it requires the institutionalization of physicians, for, wherever by law or custom, the responsibility for medical care has been assumed by institutions rather than physicians, the production has diminished, the cost increased and the quality ultimately deteriorated.

The new federal law called Medicare legalizes a change in the systems of medical care by guaranteeing payment for some medical services rendered aged citizens. In its enactment we lost a battle to prevent federal assumption of the obligation to provide personal services as a right of citizenship. As, however, the original bill was amended in its passage through the Congress, I believe we have gained an advantage in the war, which may be variously described: to preserve individual freedom in the practice of medicine, to prevent institutionalization of medical care, to prove the advantage of private sector administration of personal services over government administration.

I am convinced that sooner or later it will become clearly evident that government, especially a democracy, cannot provide personal services efficiently or economically and must contract with the private sector for medical and other personal services government is obligated to provide.

Under the provisions of federal law 89-97 Title XVIII A, hospital services will be provided all citizens 65 years of age and over. I think it inevitable that institutions providing a large percentage of these services so strictly accountable for payment from a tax fund must become regulated as agencies of government. Fortunately, payment for physicians' services is prohibited under Title XVIII A and is provided under Title XVIII B, the Voluntary Supplementary Medical Insurance Plan. Under this plan the deductibles, coinsurance, and assignment provisions will be troublesome and accentuate the need for cooperative and centralized accounting methods for physicians' services.

To meet the needs of a changing medical economy, we have developed the medical insurance carrier which may prove to be the saving adaptation to preserve medical freedom under the provisions of Title XVIII B, provided our insurance carrier, Blue Shield, can successfully resist capture by government.

Title XIX of Public Law 89-97 is no new departure from the traditional principle of government obligation to provide medical care for those in need. Indeed, this law requires high quality medical care equally available to all unable to provide for themselves and outlaws the common practice of imposing on voluntary medical institutions to give such care without adequate compensation. Physicians may now, with intelligent adaptation, regain control of their charity and restore the original meaning which is compassion as vividly defined in I Corinthians:

Though I speak with the tongues of men and of angels, and have not charity, I am become as sounding brass, or a tinkling cymbal.

And though I have the gift of prophecy, and understand all mysteries, and all knowledge; and though I have all faith, so that I could remove mountains, and have not charity, I am nothing.

And though I bestow all my goods to feed the poor, and though I give my body to be burned, and have not charity, it profiteth me nothing.

For the purpose of providing good medical care to the sick, the physician, through the hospital medical staff and component medical society, must retain responsibility for medical care in order

to have freedom to choose and prescribe a regimen for the patient as Hippocrates advised 2,500 years ago:

I swear by Apollo, the physician, that I will follow that regimen which according to my ability and judgement I consider for the benefit of my patients and abstain from whatever I consider deleterious and mischievous. . . .

Our freedom as individual physicians can survive in the changing environment only through use of new adapting methods to fulfill our medical responsibilities cooperatively and efficiently. The medical insurance carrier has been effective and can be helpful in efficiently providing services ensured the aged patient through Title XVIII B, the Voluntary Supplementary Medical Insurance Plan. Blue Shield may also be helpful in implementing the provisions of Title XIX, providing tax-supported medical care for those in need. But a companion instrument is needed whereby physicians may adapt to the new law and cooperatively fulfill their medical responsibilities with true

charity. The Florida Medical Foundation, which we created 10 years ago, lends itself well to this purpose.

Physicians as a group, therefore, lacking the obvious advantages of the fairer sex, may not successfully rely on "indecision of action" or "a profound contempt for the logic of facts" to survive the somewhat hostile environment of today. We must resort to fortitude and intelligent action to preserve medical freedom.

About the time the steam engine was being invented, Francis Bacon said, "Temperance is the virtue of prosperity, fortitude is the virtue of adversity. In morals, fortitude is the more heroic." We now have prosperity. Can we use intelligence to engender the fortitude required to successfully adapt medical practice methods to fulfill our responsibilities and thereby preserve medical freedom in the present environment? Only you and I can give the answer.

Proceedings

Ninety-Second Annual Meeting

Florida Medical Association, Inc.
Hollywood, Florida, May 12-15, 1966

General Session

Abel Seymour Baldwin Memorial Lecture

The General Session of the Ninety-Second Annual Meeting of the Florida Medical Association was called to order at 11:00 a.m. on Friday, May 13, 1966, in the Regency Room of the Diplomat Hotel, Hollywood-by-the-Sea, Florida, by President H. Phillip Hampton.

Mr. Fred Johnson, Branch Manager, Parke Davis & Co., presented to Dr. Hampton a series of framed pictures entitled "The History of Medicine." These are to be displayed in the headquarters office.

Dr. Hampton then presented the American Medical Association Awards for Humanitarian Service to Drs. Joseph E. O'Malley, of Orlando; Matthew H. Bradley, of Miami; William D. Simpson, of Orlando; Irwin S. Leinbach, of St. Petersburg, and Richard E. Perry, of St. Petersburg. These awards were for voluntary service in Viet-Nam (Dr. Leinbach was not present).

The President asked Mr. Frank Alexander, Deputy Insurance Commissioner, to stand and be recognized.

The scientific exhibit award winners were announced: First prize, the Aesculapius Award of Mead Johnson Laboratories in the amount of \$200.00 to Dr. Charles H. Carter, of Orlando, for his exhibit entitled, "Cerebral Pathology in Mental Retardation;" second prize, a check for \$50.00 from the Florida Medical Association, to Dr. Manuel Viamonte Jr. and Mr. Robert C. Stevens, of Miami, for their exhibit, "Guided Angiography;" third prize, a check for \$25.00, to Dr. Thomas W. Dorr and Mr. Donald G. Ward, of Tampa, for their exhibit, "Radioisotope Scanning in Clinical Medicine." Honorable mention was awarded to Drs. John W. Stone and Troy H. Hutchinson II, of Lakeland, for their exhibit, "Maxillofacial Problems in Otolaryngology," and to Drs. Manuel Viamonte Jr., Richard H. Greenspan and Averill A. Liebow for their exhibit, "Selective Bronchial Arteriography."

Dr. Hampton introduced Dr. Ernest B. Howard, Assistant Executive Vice President of the American Medical Association.

Dr. Howard discussed the PL 89-97 regulations insofar as they had been promulgated at the present time. He stated that Secretary Gardner, Dr. Lee and Mr. Hess had been most cooperative and gracious, but that they could not change the law. He believed that the conferences held by the officials of the American Medical Association with the Department of Health, Education, and Welfare had made the regulations somewhat more acceptable to physicians than they would have been without these conferences. He discussed what he considered to be the areas of concern in the implementation of Title XVIII, Parts A and B of Public Law 89-97; the billing methods to be used, the number of days for recertification of a patient, the utilization review committee and the legal responsibilities of physicians who serve on these committees. He further discussed the role of interns and residents in this program, the services of pathologists and radiologists, and other hospital-based physicians. In speaking of the extended care facilities, or nursing home part of the program, Dr. Howard stated that a compromise decision had been reached to allow only a 2% profit to these facilities, and many nursing homes regard this factor as grossly inadequate. In the drug portion of the program, he stated that the regulations being written give far more authority to the hospital administrator and the hospital pharmacist than to the physician who prescribes the drugs and he believed this would inevitably lead to insistence upon generic prescriptions or at least the right of the hospital pharmacist to substitute generic drugs for whatever the doctor may

prescribe. One of the best parts of this law, he thought, was the provision for home care, providing the physicians and the medical societies assume its guidance.

The application of the Civil Rights Act to this program was mentioned and Dr. Howard stated that approximately 1,000 hospitals in the country could not qualify because they did not meet these requirements. The deductibles and co-insurance, he predicted, will be very difficult to administer.

A conference will be held next Monday, he reported, to discuss such questions as the meaning of "usual and customary" as they appear in the law, and the words "prevailing" and "reasonable."

In closing, Dr. Howard predicted that the cost of both Part A and Part B would be far higher than estimated; that because of these increased costs there would be heavy pressure in the Congress to try to control the costs, which means that new regulations or laws may be passed by the Congress relating to these costs; and that these problems will bring about new controls by government over the practice of medicine and over the practice of hospitals and nursing homes. He announced that the Department of Health, Education, and Welfare is preparing a brochure for distribution to physicians, with the help of the American Medical Association, which will be very informative; also a brochure to the over-65 recipients, which the AMA did not help to prepare, and which he felt had some unfortunate implications.



Dr. Edward R. Annis, Miami, (left), past president of the AMA and Dr. Ernest B. Howard, Chicago, (right), AMA assistant executive vice president, deliver the Abel Seymour Baldwin Lecture of the General Session.

Dr. Hampton thanked Dr. Howard for giving this informative and up-to-date information on a subject of such great concern.

The President then introduced Dr. Edward R. Annis, Past President of the American Medical Association and the World Medical Association.

Dr. Annis cautioned physicians that, in their efforts to be good citizens, they not forget how this legislation was passed. It was not passed because the American people demanded it, he said, but because of a political coup by labor bosses who used the vast reservoir of labor's organization to elect a rubber-stamp Congress. When this legislation was passed, he pointed out, it was promised that there would be no interference with the doctor-patient relationship or the hospitals, or no extension of the program—they simply wanted to take care of the old people. Part B of the program, he said, was supposed to be voluntary, but when less than half of the eligible elderly people signed up for it, the government took steps to coerce major insurance companies to cancel their policies for the elderly, thus making their participation compulsory.

The American people are told that this is health insurance, he said, but it is a dole. He spoke of President Johnson's plans for care of the young, and other plans for extension of the program, although when Public Law 89-97 was passed, the government had promised there would be no extension.

He suggested that doctors should tell government and the public that they are interested in quality medicine, but that it should be quality medicine unfettered and unshackled, and in continuing the system which has given the United States the finest quality of medical care available anywhere in the world; that the physicians have no objection to allowing government to do what they said they wanted to do—merely pay the bill for those over 65—but the physicians are not government employees and will not allow the government to rule and regulate the profession. All physicians ask of the government, he concluded, is that they keep their word.

The Meeting was adjourned at 12:45 p.m.

First House of Delegates

The House of Delegates of the Florida Medical Association convened at 9:30 a.m. on Thursday, May 12, 1966 in the Regency Room of the Diplomat Hotel, Hollywood-by-the-Sea, Florida, with Dr. Franklin J. Evans, Speaker of the House, presiding.

The invocation was pronounced by Dr. Homer L. Pearson Jr.

The Speaker announced the membership of the Credentials Committee: Drs. William J. Dean, Chairman, Jack T. Bechtel and William W. Thompson.

The Chairman of the Credentials Committee, Dr. Dean, reported a quorum of 222 delegates registered out of a possible 259, and moved that they be seated.

Motion was seconded and carried.

Delegates

ALACHUA—J. -Maxey Dell Jr., Taylor H. Kirby Jr., Walter E. Murphree, William C. Ruffin Jr., George T. Singleton.
 BAY—William C. Fontaine (*Absent—Paul A. Johnson*).
 BREVARD—Jack T. Bechtel, Theodore J. Kaminski, Laudie E. McHenry Jr., Lee Rogers Jr., Ben C. Storey, Joseph C. Von Thron.
 BROWARD—Curtis D. Benton Jr., Russell B. Carson, Gordon B. Carver, Richard S. Doyle, Leonard A. Erdman, Frederick W. Fisher, Anthony C. Galluccio, Walter J. Glenn Jr., John D. Leichty, John H. Mickley, Ray E. Murphy Jr., Robert H. Pfeifer, Lees M. Schadel Jr., Diran M. Seropian, Daniel C. Smith, W. Dotson Wells.
 CHARLOTTE—Carl N. Reilly.
 CLAY—William A. Mulford.
 COLLIER—William J. Bailey.
 COLUMBIA—Laurie J. Arnold Jr.
 DADE—William A. Abelove, Julius Alexander, William G. Aten, Thomas J. Baker, Jerome Benson, Harvey E. Brown Jr., Lynn P. Carmichael, John G. Chesney, Richard C. Clay, Jack Q. Cleveland, John E. Cunio, DeWitt C. Daughtry, Richard C. Dever, Robert F. Dickey, L. Washington Dowlen, Richard M. Fleming, M. Eugene Flipse, Maurice M. Greenfield, Henry C. Hardin Jr., James J. Hutson, Harry Horwich, Marvin L. Jaffee, Walter C. Jones III, David Kirsh, John B. Liebler, Donald F. Marion, Elwin G. Neal, Edwin P. Preston, James C. Pringle Jr., William E. Riemer, Daniel L. Seckinger II, Everett Shocket, Chauncey M. Stone Jr., William M. Straight, Charles F. Tate Jr., Paul N. Unger, Scheffel H. Wright, Nelson Zivitz (*Absent—James L. Anderson, Vincent P. Corso, II, Clinton Davis, Joseph H. Davis, Benedict R. Harrow, Caroline B. Hunter, Paul S. Jarrett, Banning G. Lary, Samuel W. Page Jr., Harold Rand, George W. Robertson III, Edward W. St. Mary, Thomas W. Skaggs, Clifford C. Snyder, Joseph J. Zavertnik*).

DESOTO-HARDEE-GLADES—Gordon H. McSwain.
 DUVAL—Sam C. Atkinson, Hugh A. Carithers, William P. Clarke, Ensor R. Dunsford Jr., John J. Fisher, Lawrence E. Geeslin, W. Roy Hancock, Gordon H. Ira Sr., Thomas M. Irwin, Harry W. Reinstine, Wade S. Rizk, Richard T. Shaar, William A. Van Nortwick, Jonathan H. Wood. (*Absent—Marvin H. Johnston, Wilbur C. Sumner*).
 ESCAMBIA—Frank B. Hodnette, George W. Morse, John M. Packard, William M. C. Wilhoit, Earl G. Wolf (*Absent—Joseph Q. Perry*).
 FRANKLIN-GULF—Joseph P. Hendrix.
 GADSDEN-LIBERTY—Taylor W. Griffin.
 HIGHLANDS—Donald C. Hartwell.
 HILLSBOROUGH—Collin F. Baker Jr., Francis C. Coleman, Richard G. Connor, John C. Fletcher, Linus W. Hewit, Samuel G. Hibbs, Victor H. Knight, Eugene B. Maxwell, W. Mahon Myers, James N. Patterson, Charles L. Pope, William W. Trice Jr., James A. Winslow Jr.
 INDIAN RIVER—Erasmus B. Hardee Sr.
 JACKSON-CALHOUN—William F. Brunner.
 LAKE—Frederick C. Andrews, J. Basil Hall.
 LEE-HENDRY—Carey N. Barry, H. Quillian Jones Sr., Edward W. Salko.
 LEON-WAKULLA-JEFFERSON—Fred A. Butler, James K. Conn, Nelson H. Kraeft, Robert N. Webster.
 MADISON—(*Absent—William J. Bibb*).
 MANATEE—Warren G. Darty, Irving E. Hall Jr., Joseph F. P. Newhall Jr.
 MARION—West Bitzer, Henry L. Harrell.
 MONROE—Ralph Herzer.
 NASSAU—Daniel M. Jacobs Jr.
 OKALOOSA—William W. Thompson.
 ORANGE—Louis P. Brady, Jesse W. Castleberry, Benjamin M. Cole, Norman F. Coulter, Robert W. Curry, William R. Daniel, Truett H. Frazier, Eldridge W. Johnson, Harold W. Johnston, Louis C. Murray, Charles R. Sias, W. Dean Steward, Edward W. Stoner.
 PALM BEACH—Carl E. Andrews, Vernon B. Astler, James F. Cooney, Gabino S. Cuevas, Joseph C. Doane, Russell D. D. Hoover, Richard F. Kidder, Bernard Kimmel, William H. Proctor, Myrl Spivey, Malcolm S. Van de Water.
 PASCO-HERNANDO-CITRUS—William H. Hubbard.
 PINELLAS—Charles E. Aucremann, Edward L. Cole Jr., William J. Dean, Douglas W. Hood, David S. Hubbell, Charles A. Johnson Jr., William H. Keeler III, Jack A. MaCris, Albert B. McCreary, Joseph E. Rawlings Jr., Howard L. Reese, Richard C. Trump, Abbott Y. Wilcox Jr., Walter H. Winchester, Rowland E. Wood.
 POLK—Edward C. Burns Jr., Paul E. Coury, John W. Glotfiely, Gordon R. Heath, Charles Larsen Jr., Willard E. Manry Jr., Arthur J. Moseley Jr.
 PUTNAM—Roy E. Campbell.
 ST. JOHNS—Joseph A. Shelley.
 ST. LUCIE-OKEECHOBEE-MARTIN—John M. Gunsolus, Howard C. McDermid.
 SANTA ROSA—R. Don Bryan.
 SARASOTA—John M. Butcher, Samuel E. Kaplan, Karl R. Rolls, Melvin M. Simmons, Millard B. White.
 SEMINOLE—Charles L. Park Jr.
 SUWANNEE - HAMILTON - LAFAYETTE — Jack A. Voight.

TAYLOR—James A. Rawls Jr.
VOLUSIA—Michael R. Blais, C. Robert DeArmas, Thurman Gillespy Jr., William H. Harrison Jr., Charles L. Rickerd.

WALTON—(Absent—McKinley Cheshire Jr.)

WASHINGTON-HOLMES—(Absent—Walter H. Shehee).

COUNCIL ON SPECIALTY MEDICINE—Andre S. Capi, James W. Clower Jr., Edward W. Cullipher, Charles K. Donegan, Emmet F. Ferguson Jr., David W. Goddard, Sanford A. Mullen, Walter W. Sackett Jr. (Absent—James D. Beeson, Jack H. Bowen, J. Alfred Bowers, Marlin C. Moore, Bernard L. N. Morgan, Curtis G. Rorebeck, Thomas E. Scott Jr.).

DELEGATES TO A.M.A.—Jere W. Annis, Reuben B. Chrisman Jr., Burns A. Dolbins Jr., Francis T. Holland, Robert E. Zellner.

PAST PRESIDENT A.M.A.—Edward R. Annis.

OFFICERS—James T. Cook, Samuel M. Day, Franklin J. Evans, H. Phillip Hampton, Floyd K. Hurt, George S. Palmer, Eugene G. Peek Jr.

BOARD OF PAST PRESIDENTS—Jere W. Annis, Samuel M. Day, Ralph W. Jack, Edward Jelks, Walter C. Jones, Francis H. Langley, John D. Milton, Walter C. Payne Sr., Homer L. Pearson Jr., Eugene G. Peek Sr., Warren W. Quillian, William C. Roberts, Leo M. Wachtel, Robert E. Zellner (Absent—Orion O. Feaster, Frederick K. Herpel, Duncan T. McEwan, Robert B. Melver, William M. Rowlett, Joseph S. Stewart, William C. Thomas Sr., Frederick J. Waas).

The Speaker stated that there had been a change this year in the order of business and in order that there be no misunderstanding or future challenge, he asked for a motion approving the "Information for Delegates" as printed on page 1 of the Handbook.

Information for Delegates

The Order of Business for both meetings of the House of Delegates is included in this Handbook.

Delegates and alternates whose names appear in this Handbook have been certified by their county medical societies. Our By-Laws do not permit an alternate to serve for a delegate who has once been seated. The By-Laws require that delegates fill out attendance cards at each meeting of the House of Delegates in order to be credited in attendance, and further, the Chairman of the Credentials Committee is required to report to the House the number of delegates who have registered their attendance cards, thus eliminating the necessity of a roll call to seat delegates.

Reports and resolutions that were received before going to press are included in this Handbook. Delegates are urged to study them carefully before they are introduced in the House. Whenever possible, it is requested that Resolutions and supplemental reports be forwarded to the Association's executive office by April 30 for duplication and distribution to the delegates.

All reports and resolutions will be referred to Reference Committees by the Speaker at the First Meeting of the House of Delegates. All members who are interested in any committee report or resolution are invited to attend the Reference Committee meetings where a full discussion will take place. All members of Reference Committees are urged to study carefully the reports and resolutions referred to them. The chief purpose of the Reference Committees is to allow an opportunity for as many members of the Florida Medical Association as possible to appear and be heard and thus have a voice in the business of the Association. In addition, discussions before the Reference Committees have the added advantage of avoiding long discussions at the meetings of the House of Delegates.

Your attention is called to the Report of the Board of Governors which contains the recommendations that a resolution before a Reference Committee must have a

sponsor present before the Reference Committee; otherwise, the resolution is automatically dead; and that all resolutions must be filed by 6:00 p.m. on the day preceding the First Meeting of the House of Delegates. Barring any objections, we will abide by these recommendations at this annual meeting. Your attention is also called to the change in the format of the annual meeting, where the Reference Committee meetings will be held in the afternoon following the First Meeting of the House. We also plan to have all Reference Committee reports duplicated and available to the delegates at the Registration Desk the day preceding the Second Meeting of the House of Delegates. We trust these changes will result in a more efficient and informed House of Delegates.

Your Speaker and Vice-Speaker are available at any time to help in any way in the preparation of resolutions or in any capacity in which they might help any member of the Florida Medical Association.

Franklin J. Evans,
Speaker, House of Delegates

James T. Cook,
Vice-Speaker, House of Delegates

Motion was made, seconded and carried.

The Speaker introduced the officers of the Association: H. Phillip Hampton, M.D., President; George S. Palmer, M.D., President-Elect; Samuel M. Day, M.D., Immediate Past President; Eugene G. Peek Jr., M.D., Vice President; James T. Cook, M.D., Vice Speaker of the House; Floyd K. Hurt, M.D., Secretary-Treasurer, and Mr. W. Harold Parham, Executive Director.

The Speaker then instructed the House:

Remarks of the Speaker

At this time the Speaker would like to make a few comments which you have heard before, but still, I think, are worthy of repetition. The Association, as you know, some years ago switched over to the speaker type of management of the House of Delegates. The purpose of the Speaker and the Vice Speaker is merely to guide the meeting so as to give it good direction, to permit each member to express himself in an orderly fashion. It is the desire of the Speaker and the Vice Speaker that each person be permitted the time he needs but that it be done in an orderly manner and that he ask for recognition from the Chair and this will be granted to him.

There has been some criticism in the past regarding the manner in which the House of Delegates met and the fact that the delegates were not well informed as to what was going on. The Board of Governors thought that these objections were well taken; so there are some changes this year in the format of the House of Delegates' meeting.

In the first place, the rule was passed that all resolutions would have to come before the Florida Medical Association in writing and no later than 6:00 p.m. on the night before the meeting of the House of Delegates. The reason for this is obvious. Some resolutions have come in; they have been duplicated during the night and today have been distributed to you. So you now have a copy of them. This change will lead to better information on your part.

Secondly, there was a complaint that at the Reference Committee meetings resolutions which had been introduced were not sponsored by anyone at the Reference Committee meeting. The rule is now that if any society or delegate who has introduced a resolution does not appear at the Reference Committee meeting, such resolution will be automatically rejected as not having a sponsor. The reason again is obvious. Frequently the Reference Committee has no knowledge or idea of what was desired by the resolution and unless someone comes forward and speaks

for it, the Reference Committee cannot give a very good opinion or judgment on it. Again, we ask that those who have introduced resolutions appear before the Reference Committee, which does the spade work for the House of Delegates.

We would like to make this a smooth-running organization. We want every delegate to be very well informed, and this is the purpose of printing this information and distributing it to you.

One other change I think you will approve. The work of the Reference Committee will be documented and duplicated, and will be in your hands the day before the second meeting of the House of Delegates, so that when these matters are discussed at the second meeting, you will have had an opportunity to look at them, study them and be prepared to do what you wish with them. We believe that this is a progressive step forward to make each of our delegates more informed, so that he might participate with wisdom in the discussion of the House.

We will follow these rules and hope that in the future other suggestions will be brought forward to improve the House. Your Board of Governors is very sensitive to what each member desires.

Two distinguished guests were introduced: Mrs. H. Quillian Jones, President, Woman's Auxiliary to the Florida Medical Association, and Mrs. Allen E. Kuester, President-Elect of the Woman's Auxiliary.

The Honorable Fletcher G. Rush, President-Elect of The Florida Bar was introduced.

Mr. Rush brought greetings from the 9,500 members of The Florida Bar and expressed appreciation for the opportunity to speak to the House. He contrasted the battle which the doctors have fought against Medicare with the lack of opposition with which a similar problem was thrust upon the legal profession, who have found that by administrative interpretation under the Economic Opportunity Act of 1964, they are faced with "Judicare." Under the broad provisions of this Act, the legal profession must now provide legal services to the poor. He thought that the legal profession would find some way to provide these services, but it must be done in such a way as to maintain the high standards and ethical principles of the profession. He also reported on two interesting programs of The Florida Bar; one, to establish, if given permission by the Supreme Court, a "client's security fund," which will restore to a client money or property lost through the dishonest act of a lawyer, and the second, a program of judicial reform in Florida.

The Speaker called attention to the five physicians who are running for seats in the legislature and commented that they deserved the support of the members, as it would be good for the profession and also good for the state as a whole to have physicians in the legislature.

Dr. Hampton presented the A. H. Robins Company "Annual Award for Outstanding Com-



Dr. H. Phillip Hampton of Tampa, President, presents the A. H. Robins Community Service Award to Dr. James A. Long Jr. of Palatka.

munity Service by a Physician" to James A. Long Jr., M.D. of Palatka, who was escorted to the rostrum by Roy E. Campbell, M.D.

A. H. Robins Company Award

"For Outstanding Community Service by a Physician"

Dr. James A. Long Jr. of Palatka is the recipient of the 1966 Community Service Award of the A. H. Robins Company. Annually this signal honor is accorded a member of the Florida Medical Association who has rendered distinguished service in civic and community activities. The Association's Board of Governors makes the choice from candidates who are nominated by the component county medical societies.

Dr. Long was born in Daytona Beach on December 21, 1898. He attended Howard University for both college and medical school and received his medical degree in 1925. Dr. Long served his internship at City Hospital in Kansas City, Missouri. In January 1928 he started the practice of medicine in Palatka, where he has been practicing since. During the war years Dr. Long was one of only three physicians practicing in the county.

During his 38 years of practice Dr. Long has been active in community and medical life and has made tremendous contributions in all aspects of both civic and medical life in Putnam and surrounding counties. In spite of having one of the most active practices in the county, consisting of both white and colored patients, he has found time to keep up with the improvements in medicine and has freely donated his time and money to improve the living standards of both white and colored citizenry, not only of Putnam County, but of the neighboring counties of St. Johns and Volusia.

Dr. Long was admitted to the Putnam County Medical Society in 1950 and was the sixth Negro admitted to the Florida Medical Association. He has served his county medical society as secretary-treasurer for two terms and as president during the year 1965. During each term and with each office he has served efficiently and with honor, which has been reflected upon both himself and the medical society in general.

Always interested in the welfare of the state, Dr. Long has served on the Hospital Service for the Indigent Medical Advisory Committee to the State Board of Health, having been appointed by Governor Leroy Collins for two terms—a total of eight years of service.

Dr. Long is now college physician for Florida Normal College in St. Augustine, a position which he has held



Dr. Charles J. Collins of Orlando is congratulated by Dr. H. Phillip Hampton of Tampa, President, following presentation of the Certificate of Merit, the Association's highest award.

for the past 20 years. He is an active staff member of the Putnam Memorial Hospital, having been one of the originally appointed staff members of that institution.

The dedication of this man is untiring and his accomplishments are legion. He is a past president of the Florida Medical, Dental and Pharmaceutical Association, and has served as secretary-treasurer of the Medical Section of that organization for 28 years. Dr. Long has also served for that organization in the national Medical, Dental and Pharmaceutical Association.

Dr. Long held the office of Secretary of the House of Delegates of the National Medical Association, Inc., for eight consecutive years and was Speaker of the House for two years. He also served as a member of its Board of Trustees for four years.

Dr. Long's contributions to the field of organized medicine and patient care have been great. His vision was wide enough to note the needs for improved educational and cultural standards in his community and he has donated tremendous amounts of his time and effort to furthering improvements in this area. His contribution in the field of education has been gigantic. He is on the Executive Board of Trustees of Bethune Cookman College in Daytona Beach and is presently Chairman of the Building and Grounds Committee, which at this time has three buildings under construction.

Since its inception six years ago, Dr. Long has been on the Advisory Committee for the Collier Blocker Junior College in Palatka and has served as Chairman for three years. In this capacity he has also been a very active contributing member.

The Putnam County School Board holds Dr. Long in such esteem that one of the larger elementary schools in Palatka was named in his honor in 1961. Dr. Long is presently a member of the Advisory Committee to the Putnam County School Board.

Dr. Long is a Mason, a Shriner and an Elk. He is a Past Exalted Ruler of the local Elks Club and is Chief Antler of the Past Exalted Rulers Council for his district.

Spiritual life is also important to Dr. Long and is as outstanding as are other aspects of his life. Since moving to Palatka he has been a member of the Bethel A.M.E. Church and for 37 years has been a member of the Board of Trustees of that church. In 1959, his church held a recognition day service for him in which all elements of his community, as well as surrounding sections, participated in honoring him. In remembrance of his mother, Dr. Long had chimes installed in the belfry of his church in 1944. These chimes which he donated call attention daily at 6:00 p.m. to the higher spiritual aims of the

church and cause the people of Palatka to reflect about God and these heavenly values.

The superior character, influence and guidance of Dr. Long have been a monumental factor in the harmonious relationship between the white and Negro citizenry of his county. He has been a member of the Bi-Racial Committee since its inception in 1963 and is presently serving as its vice-chairman. The peaceful racial relationships current in his community are a tribute to Dr. Long's efforts and guidance to both races during a time when national and local demonstrations have done so much to stir up animosity.

Dr. Long married Goldie Holmes while an intern in Kansas City. The Longs have one daughter, Mary Ellen, who is a school psychologist in the Washington, D. C., school system.

Dr. Hampton asked Mrs. Long to stand and be recognized.

Dr. Long: "Dr. Hampton, Members of the House of Delegates: It is indeed a pleasure for me to receive and accept this award. It really came as a surprise to me. The members of my society really kept it a secret."

Dr. Robert E. Zellner was recognized and requested the unanimous consent of the House for the presentation of the Certificate of Merit. Motion was made, seconded and carried.

Dr. Hampton asked Dr. Zellner and Dr. William R. Daniel to escort Dr. Charles J. Collins to the rostrum. The House gave Dr. Collins a standing ovation.

Dr. Hampton presented to Dr. Collins the Certificate of Merit, the Association's highest honor.

Certificate of Merit

Whereas, Charles Joseph Collins, M.D., of Orlando, a life member of the Florida Medical Association, has rendered distinguished service to the public, to the medical profession and to the Association for forty years and is deemed worthy of the Association's highest award; and

Whereas, This distinguished physician was born in St. Augustine, Florida, on March 23, 1900; was reared in Cartersville, Georgia; received his premedical education at the University of Georgia, Athens; was granted the degree of Doctor of Medicine in 1921 by Emory University School of Medicine, Atlanta; served an internship at Grady Memorial Hospital, Atlanta, and residencies at St. Joseph's Hospital and the United States Marine Hospital, Savannah; and is a veteran of both World Wars; and

Whereas, This native Floridian entered the private practice of medicine in August 1925, in Orlando, where for four decades he has continued to practice obstetrics and gynecology, and more recently infertility and endocrinology; has an outstanding record of service to his community and to his profession; is a former chief of the medical staff at Orange Memorial Hospital, also a past chief of Obstetrics and a past chief of Gynecology, and now is a member of the consulting staff in Gynecology; was largely instrumental in the establishment of an approved residency program in Obstetrics and Gynecology at Orange Memorial Hospital; has held numerous committee assignments in the Orange County Medical Society, of which he was president in 1940 and subsequently served as chairman of its public relations committee, and as delegate to the Florida Medical Association for many years and member of the Executive Council; and

Whereas, This outstanding physician has served in many and varied capacities in the Florida Medical Association; is a former second vice president of the Association; was a member of the Committee on Publications and on the editorial staff of The Journal of the Florida Medical Association from 1954 to 1960; was a member of the Committee on Scientific Work for four years, serving as chairman in 1954; has been a member of the Committee on Postgraduate Education since 1961; is a past chairman of the Committee on Fee Schedules; served on the Board of Governors from 1961 to 1965; and became a life member of the Association in 1961; and

Whereas, This able medical leader was president of the Southern Obstetrical and Gynecological Society in 1955, Florida Obstetric and Gynecologic Society in 1948, South Atlantic Association of Obstetricians and Gynecologists in 1958 and 1959, and Florida State Board of Health from 1955 to 1959; was Florida state chairman of the American Academy of Obstetrics and Gynecology in 1952; is a former chairman of the section on gynecology of the Southern Medical Association; is a member of the Medical Advisory Committee of the University of Florida College of Medicine and former lecturer in gynecology at that institution; has been a member of the Board of Directors of the American Fertility Society since 1962 and currently is its president-elect; and is a diplomate of the American Board of Obstetrics and Gynecology; therefore, be it

RESOLVED, That the Certificate of Merit, the Association's highest honor, be presented to this fine gentleman, eminent member of the Association, scholar, teacher, community and professional leader, in recognition of his unselfish service and generous expenditure of time and effort through the years on behalf of the public, the profession, and the Association.

Dr. Collins: "Dr. Hampton, Members of the House of Delegates, and Guests: This was completely unexpected this morning. To those of you who watch television, particularly in the Miami area, I am sure you are familiar with the

greeting, 'How sweet it is.' This is the greatest honor I have ever received in my life and I am grateful for it. I have received other honors outside the state of Florida, all I feel undeserved; but, you know, it is easy to fool the people out of state, but when you receive such an honor from those you work with and with whom you share your life every day, it is particularly meaningful. I am deeply grateful to my county medical society of Orange for nominating me for this award. Thank you from the bottom of my heart."

The Speaker asked Mrs. Collins to stand and be recognized.

Mr. Harry T. Gray, legal counsel for the Florida Medical Association, was asked to stand and be recognized.

The Speaker introduced the President, Dr. H. Phillip Hampton, who gave his presidential address.

(The complete text of President Hampton's address begins on page 583.)

Following his address, the House gave Dr. Hampton a standing ovation.

The Speaker announced that the President's address would be referred to Reference Committee No. III.

Approval was requested by the Speaker of the minutes of the last annual meeting held April 22-25, 1965 as published in the June 1965 issue of The Journal of the Florida Medical Association.



Florida physicians who joined the FMA between 1927 and 1931 were honored by the House of Delegates and later gathered for a special meeting where further recognition was accorded them. Pictured, from l. to r., are Drs. J. Ralston Wells, DeLand, Leroy H. Oetjen, Leesburg; Thomas C. Kenaston, Cocoa; Francis H. Langley, St. Petersburg; John E. Maines Jr., Gainesville; Eugene B. Maxwell, Tampa; Reddin Britt, St. Augustine; D. Ward White, Miami Beach and Allan Jones, Orlando.

Motion was made, seconded and carried to approve the minutes as published.

The Speaker announced the personnel of Reference Committees and times and places of their meetings as follows:

- I. Health and Education
Maurice M. Greenfield, Chairman
West Bitzer
Millard B. White
W. Dotson Wells
James L. Anderson
- II. Public Policy
George W. Morse, Chairman
Laurie J. Arnold Jr.
Abbott Y. Wilcox Jr.
Russell D. D. Hoover
Richard C. Clay
- III. Finance and Administration
Jere W. Annis, Chairman
William A. Van Nortwick
James A. Winslow Jr.
Charles R. Sias
Nelson Zivitz
- IV. Legislation and Miscellaneous
Louis C. Murray, Chairman
Fred A. Butler
Francis C. Coleman
David W. Goddard
David Kirsh

Meetings:

- I. 3:30 p.m. Health and Education—
Seminar Room #3
- II. 3:00 p.m. Public Policy—
Seminar Room #1
- III. 2:30 p.m. Finance & Administration—
Seminar Room #2
- IV. 2:00 p.m. Legislation & Miscellaneous—
Regency Room

Dr. Evans stated that all reports and resolutions would be found either in the Handbook or in the delegates' packets.

Dr. William M. Straight, Chairman, Committee on Archives, was recognized.

Dr. Straight: "Mr. Speaker, Fellow Physicians and Guests: At this annual meeting we would first like to recognize those members of our Association who joined the Florida Medical Association between 1927 and 1931. We have attached to their identification badges a ribbon in honor of this occasion. At 1:00 p.m. today in the Embassy Room, we will have a reception in honor of these

physicians. At this time will all members who joined the Association between 1927 and 1931 please stand to be recognized?"

The House applauded.

Dr. Straight: "For the next few moments, we pause to honor those of our members who have left us for their eternal reward since our last gathering. Their names appear in your supplemental packet. For each of these physicians, 64 in number, a rose has been placed in the vases on the speaker's table."

At the request of Dr. Straight, the House stood for a moment of silent reverence in memory of their deceased colleagues.

The Speaker announced that the supplemental report of the Committee on Archives would be assigned to Reference Committee No. III.

Other supplemental reports and resolutions which were received too late to be included in the Handbook, but were in the delegates' packet, were referred by the Speaker to the appropriate Reference Committees.

Dr. Maurice Greenfield requested and was granted the unanimous consent of the House to present a noncontroversial resolution regarding training of paramedical personnel, which was given No. 66-33 and assigned to Reference Committee No. II.

Dr. Jack Q. Cleveland requested and was granted the unanimous consent of the House to present a noncontroversial resolution regarding FLAMPAC, which was given No. 66-34 and assigned to Reference Committee No. IV.

The Speaker announced that the Annual Meeting of Florida Blue Shield would be held immediately following recess of the House of Delegates' meeting in the same room; that the President's Guest Speakers will speak at 11:00 a.m. on Friday, May 13; also, a joint luncheon of FLAMPAC and the Woman's Auxiliary on Friday, May 13, at 12:30 p.m. in Les Ambassadeurs Dining Room with the Honorable Justice Millard Caldwell as guest speaker.

The House recessed at 10:50 a.m. to reconvene on Sunday, May 15, 1966 at 9:30 a.m.

Second House of Delegates

The House of Delegates reconvened at 9:30 a.m. on Sunday, May 15, 1966, in Les Ambassadeurs Room of the Diplomat Hotel, Hollywood-by-the-Sea, Florida, with Dr. Franklin J. Evans, Speaker of the House, presiding.

Dr. William J. Dean, Chairman of the Credentials Committee, reported 205 delegates registered, constituting a quorum and moved that they be seated.

Motion was seconded and carried.

Delegates

ALACHUA—J. Maxey Dell Jr., Taylor H. Kirby Jr., Walter E. Murphree, William C. Ruffin Jr., George T. Singleton.
 BAY—William C. Fontaine (*Absent—Paul A. Johnson*).
 BREVARD—Jack T. Bechtel, Theodore J. Kaminski, Laudie E. McHenry Jr., Lee Rogers Jr., Ben C. Storey, Joseph C. Von Thron.
 BROWARD—Russell B. Carson, Frederick W. Fisher, Anthony C. Galluccio, Walter J. Glenn Jr., John D. Leichty, John H. Mickley, Ray E. Murphy Jr., Lees M. Schadel Jr., Daniel C. Smith, W. Dotson Wells (*Absent—Curtis D. Benton Jr., Gordon B. Carver, Richard S. Doyle, Leonard A. Erdman, Robert H. Pfeifer, Diran M. Seropian*).
 CHARLOTTE—(*Absent—Carl N. Reilly*).
 CLAY—William A. Mulford.
 COLLIER—William J. Bailey.
 COLUMBIA—Laurie J. Arnold Jr.
 DADE—William A. Ablove, Julius Alexander, James L. Anderson, Thomas J. Baker, Jerome Benson, Harvey E. Brown Jr., Lynn P. Carmichael, Richard C. Clay, Jack Q. Cleveland, John E. Cunio, DeWitt C. Daughtry, Richard C. Dever, Robert F. Dickey, L. Washington Dowlen, Richard M. Fleming, M. Eugene Flipse, Maurice M. Greenfield, Henry C. Hardin Jr., James J. Hutson, Harry Horwich, Marvin L. Jaffee, Paul S. Jarrett, Walter C. Jones III, David Kirsh, John B. Liebler, Carlos G. Llanes, Donald F. Marion, Paul W. Mayer, Elwin G. Neal, Edwin P. Preston, James C. Pringle Jr., Guillermo A. Puente-Duany, William E. Riemer, Daniel L. Seckinger II, Everett Shocket, William M. Straight, Charles F. Tate Jr., Paul N. Unger, Scheffel H. Wright, Nelson Zivitz (*Absent—William G. Aten, John G. Chesney, Joseph H. Davis, Benedict R. Harrow, Caroline B. Hunter, Banning G. Lary, Harold Rand, George W. Robertson III, Edward W. St. Mary, Thomas W. Skaggs, Clifford C. Snyder, Chauncey M. Stone Jr., Joseph J. Zavertnik*).
 DESOTO-HARDEE-GLADES—Gordon H. McSwain.
 DUCAL—Hugh A. Carithers, William P. Clarke, Ensor R. Dunsford Jr., Thomas S. Edwards, John J. Fisher, Donald B. Frazier, Lawrence E. Geeslin, W. Roy Hancock, Gordon H. Ira Sr., Thomas M. Irwin, Harry W. Reinstine, Wade S. Rizk, Richard T. Shaar, William A. Van Nortwick, Jonathan H. Wood (*Absent—Sam C. Atkinson*).

ESCAMBIA—Frank B. Hodnette, George W. Morse, John M. Packard, William M. C. Wilhoit, Earl G. Wolf (*Absent—Joseph Q. Perry*).
 FRANKLIN-GULF—Joseph P. Hendrix.
 GADSDEN-LIBERTY—Taylor W. Griffin.
 HIGHLANDS—Donald C. Hartwell.
 HILLSBOROUGH—Collin F. Baker Jr., Francis C. Coleman, Richard G. Connar, John C. Fletcher, Linus W. Hewit, Samuel G. Hibbs, Victor H. Knight, Eugene B. Maxwell, W. Mahon Myers, James N. Patterson, Charles L. Pope, William W. Trice Jr., James A. Winslow Jr.
 INDIAN RIVER—Erasmus B. Hardee Sr.
 JACKSON-CALHOUN—William F. Brunner.
 LAKE—Frederick C. Andrews, J. Basil Hall.
 LEE-HENDRY—H. Quillian Jones Sr., Edward W. Salko (*Absent—Carey N. Barry*).
 LEON-WAKULLA-JEFFERSON—Fred A. Butler, Nelson H. Kraeft, Robert N. Webster (*Absent—James K. Conn*).
 MADISON—(*Absent—William J. Bibb*).
 MANATEE—Warren G. Darty, Irving E. Hall Jr., Joseph F. P. Newhall Jr.
 MARION—West Bitzer, Henry L. Harrell.
 MONROE—Ralph Herz.
 NASSAU—(*Absent—Daniel M. Jacobs Jr.*).
 OKALOOSA—William W. Thompson.
 ORANGE—Louis P. Brady, Jesse W. Castleberry, Benjamin M. Cole, Norman F. Coulter, Robert W. Curry, William R. Daniel, Truett H. Frazier, Eldridge W. Johnson, Harold W. Johnston, Louis C. Murray, Charles R. Sias, W. Dean Steward, Edward W. Stoner.
 PALM BEACH—Carl E. Andrews, Vernon B. Astler, James F. Cooney, Gabino S. Cuevas, Joseph C. Doane, Russell D. D. Hoover, Bernard Kimmel, William H. Proctor, Myrl Spivey, Malcolm S. Van de Water (*Absent—Richard F. Kidder*).
 PASCO-HERNANDO-CITRUS—William H. Hubbard.
 PINELLAS—Charles E. Aucremann, Edward L. Cole Jr., William J. Dean, Douglas W. Hood, David S. Hubbell, Charles A. Johnson Jr., William H. Keeler III, Jack A. MaCris, Albert B. McCreary, Joseph E. Rawlings Jr., Howard L. Reese, Richard C. Trump, Abbott Y. Wilcox Jr., Walter H. Winchester, Rowland E. Wood.
 POLK—Edward C. Burns Jr., Paul E. Coury, John W. Glotfelty, Charles Larsen Jr., Willard E. Manry Jr., Arthur J. Moseley Jr. (*Absent—Gordon R. Heath*).
 PUTNAM—(*Absent—Roy E. Campbell*).
 ST. JOHNS—Joseph A. Shelley.
 ST. LUCIE-OKEECHOBEE-MARTIN—John M. Gunsolus, Howard C. McDermid.
 SANTA ROSA—(*Absent—R. Don Bryan*).
 SARASOTA—John M. Butcher, Samuel E. Kaplan, Karl R. Rolls, Melvin M. Simmons, Millard B. White.
 SEMINOLE—Charles L. Park Jr.
 SUWANNEE - HAMILTON - LAFAYETTE — (*Absent—Jack A. Voight*).
 TAYLOR—(*Absent—James A. Rawls Jr.*).
 VOLUSIA—C. Robert DeArmas, Thurman Gillespy Jr., William H. Harrison Jr., Charles L. Rickard (*Absent—Michael R. Blais*).
 WALTON—(*Absent—McKinley Cheshire Jr.*).
 WASHINGTON-HOLMES—(*Absent—Walter H. Shehee*).

COUNCIL ON SPECIALTY MEDICINE—James W. Clower Jr., Edward W. Cullipher, Charles K. Donegan, Emmet F. Ferguson Jr., David W. Goddard, Sanford A. Mullen, Walter W. Sackett Jr. (*Absent*—James D. Beeson, Jack H. Bowen, J. Alfred Bowers, Andre S. Capi, Marlin C. Moore, Bernard L. N. Morgan, Curtis G. Rorebeck, Thomas E. Scott Jr.).

DELEGATES TO A.M.A.—Jere W. Annis, Reuben B. Chrisman Jr., Burns A. Dobbins Jr., Francis T. Holland, Robert E. Zellner.

PAST PRESIDENT—A.M.A.—Edward R. Annis.

OFFICERS—James T. Cook, Samuel M. Day, Franklin J. Evans, H. Phillip Hampton, Floyd K. Hurt, George S. Palmer, Eugene G. Peek Jr.

BOARD OF PAST PRESIDENTS—Samuel M. Day, Ralph W. Jack, Walter C. Jones, Francis H. Langley, John D. Milton, Homer L. Pearson Jr., Eugene G. Peek Sr., Warren W. Quillian, William C. Roberts, Leo M. Wachtel (*Absent*—Orion O. Feaster, Frederick K. Herpel, Edward Jelks, Duncan T. McEwan, Robert B. McIver, Walter C. Payne Sr., William M. Rowlett, Joseph S. Stewart, William C. Thomas Sr., Frederick J. Waas).

The Speaker recognized guests from allied professions: Dr. Fred Hasty, Secretary and President-Elect of the Florida State Dental Society;

Mrs. Wava D. Hartsel, President, Florida Nurses Association; Mr. Jack W. Carlton, President, Florida Society of Radiological Technologists; Mr. Richard A. Kurras, Chief Delegate, Florida Chapter, American Physical Therapy Association; Mrs. Helen Hill James, President, Florida Licensed Practical Nurses Association; Mr. Allen G. Caldwell, Florida Society of Medical Technologists; Mrs. Merle Alexander, Florida Medical Assistants Association.

Dr. Hampton presented to Dr. Hayden C. Nicholson, Dean of the University of Miami School of Medicine, a check in the amount of \$3,213.44 from the American Medical Education and Research Foundation, which is a contribution free of all restrictions as to use. Another check, in the amount of \$3,510.94 was presented to Dr. Emanuel Suter, Dean of the University of Florida College of Medicine.

Report of Reference Committee

No. 1

Health and Education

Dr. Maurice M. Greenfield: "Mr. Speaker, Mr. President and Members of the House of Delegates:

"Your Reference Committee on Health and Education has considered each of the items referred to it and submits the following report. The Committee's recommendation on each item will be submitted separately and we request that each item be acted upon separately before proceeding to the next.

"The Reference Committee considered the report of the Council on Medical Education and Hospitals and recommends approval of the report as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried without opposition.

Council on Medical Education and Hospitals

HUGH A. CARITHERS, Chairman

Council:

The Council met on two occasions during the year. The meeting held in April, attended by the deans of Florida's two medical schools, produced the background



Members of Reference Committee I included Drs. Maurice M. Greenfield, chm., West Bitzer, Millard B. White, W. Dotson Wells and James L. Anderson.

material for the article by the Council "A Third Medical School in Florida?"

Following the meeting of August 1, 1965, the following recommendations were sent to the Board of Governors and were subsequently approved:

1. . . . the Council does not favor another medical school until such time as both medical schools now in existence are being used to their fullest capacity and have reached their maximum development; moreover, it is recommended that the Florida Medical Association make every effort to become better acquainted with the problems existing in our two medical schools.
2. . . . the Council urges that the Florida Medical Association become intimately involved in the formation of any future medical school in the state, including the proposed medical school at the University of South Florida.

3. . . . a joint meeting between the State Legislative Committee and the Council on Medical Education and Hospitals be held relative to these items.

As a carry-over from last year's activities of the Council, each county medical society was written on two occasions urging the formation of a voluntary health facilities planning council.

Committees:

Internships and Residencies—For the third time within recent years, a brochure on internships and residencies was mailed to 5,800 senior medical students in the United States. The brochure pointed out the advantages of "Florida's Medical Climate."

The committee surveyed 20 hospitals regarding professional liability insurance in their training program; all but two hospitals replied to the questionnaire. Of the 20 hospitals, 15 do have a professional liability insurance program for their interns and residents; three do not. Sixteen hospitals provide professional liability insurance coverage, while 2 hospitals require the individual to furnish his own coverage. The majority are covered under the hospital's professional liability coverage.

Recommendations:

That the Florida Medical Association continue to prepare, edit, update and mail brochure to graduating seniors, requesting participating hospitals to contribute helpful additions to the brochure and to contribute toward cost of publication and distribution.

That the Florida Medical Association encourage hospitals to provide adequate professional liability insurance for interns and residents and to encourage hospitals to have a discussion of professional liability insurance as part of the educational program for the interns and residents.

Encourage "family practice" programs both in graduate and postgraduate education.

Medical Schools—The Committee on Medical Schools has cooperated with the deans of our medical schools during the year, both by letter and by meeting. Important meetings were those of Sunday, December 12, 1965, and the meeting of November 21, 1965, which was held in conjunction with representative of the Florida Academy of General Practice. The following points were agreed upon by those present as recommendations for use in working further on the problem:

1. The general practitioner is indispensable to the future practice of medicine.
2. There is a shortage of general practitioners and there will be an even greater shortage in the future.
3. This shortage is true both in rural and urban areas.
4. One of the factors of this shortage is methods of education and training.
 - a. The education and training programs should be carefully considered and of the highest standards.

The following are possibilities as an approach to solve the problem:

1. Improve rapport between general practitioners and faculty members.
2. Encourage general practitioners to teach, as outlined in the committee's meeting minutes.
3. Encourage preceptorships for students.
4. Create a residency in general practice.
5. Encourage hospital privileges for general practitioners commensurate with their training.

It is suggested that this Committee be continued to assist the deans of the medical schools with the problems of General Practice.

Physician Placement—During the period covered by this report, the Committee continued its two basic functions of (1) establishing policy for and supervising operation of the Association's Physician Placement Service, and (2) serving along with faculty representatives of the state's two medical schools, as advisory committee to the State Medical Student Scholarship Program, which is

administered by the State Board of Health. One official meeting of the Committee was held, on April 21, 1965.

With respect to the state scholarship program, the Committee recommended in 1965 that if certain revisions could not be made, the program should be abolished and phased out. This recommendation subsequently received the concurrence of the Board of Governors.

The following statistics reflect the activities of the Physician Placement Service for the calendar year 1965. The total number of Florida practice opportunities listed (685) represents an increase of 84 over the previous year. The total number of physicians seeking placement assistance by registering with the Association was 617, a gain of 73 over 1964.

Concerning supply and demand in the various specialties, there were no significant changes or trends contrasting with those of the previous year, other than a general increase in opportunities and physicians in a majority of specialties. The only possible exception was a sizable increase in general practice opportunities, without a corresponding gain in the number of general practitioners available. The greatest opportunities in Florida apparently continue to be in general practice, pediatrics, otolaryngology and occupational or industrial medicine.

Listings with FMA Physician Placement Service—1965

FIELD OF MEDICINE	OPPORTUNITIES	PHYSICIANS
General Practice	274	114
Internal Medicine	105	112
Pediatrics	56	29
Otolaryngology	41	16
General Surgery	28	97
Radiology	26	35
Obstetrics-Gynecology	24	57
Ophthalmology	23	28
Orthopedic Surgery	22	20
Psychiatry	22	22
Urology	17	22
Occupational Medicine	10	3
Anesthesiology	8	16
Dermatology	8	14
Pathology	8	9
Neurosurgery	7	4
Administrative Medicine	5	6
Allergy	1	5
Plastic Surgery	0	5
Colon and Rectal Surgery	0	1
Neurology	0	1
Physical Medicine-Rehabilitation	0	1
TOTALS	685	617

"The Committee considered the supplemental report of the Council on Medical Education and Hospitals found in your delegates' packet and recommends that this report be amended."

Dr. Greenfield read the amended report in its entirety.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Supplemental Report

The Council on Medical Education and Hospitals presents the following resolution for adoption by the House of Delegates:

Whereas the University of Miami School of Medicine with a first year class of 80 students receives an annual appropriation of \$4,500 per Florida student (\$3,500 prior to 1965) which is limited by present law to 75 students; therefore be it

Resolved, That the Florida Legislature be urged to increase the number of students permitted for subsidy by the State at the University of Miami School of Medicine to 105; and be it further

Resolved, That the Board of Regents be urged to take the necessary steps, at the earliest possible date, to increase the first year class at the University of Florida College of Medicine.

Dr. Greenfield: "The Reference Committee considered the report of the Scientific Council and recommends approval of the report as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Scientific Council

RICHARD C. DEVER, *Chairman*

Council:

The Scientific Council held one formal meeting during the period covered by this report: October 10, 1965, in Orlando. At this meeting, detailed discussions were held of every facet of the Association's scientific activities.

The 1965-66 Association year may be characterized as a time of evaluation and planning for the Scientific Council. With acceptance of the strong conviction that scientific endeavors are the very core of medicine's existence, the Council has attempted to develop a new and expanded emphasis upon the Association's entire scientific program.

Specialization, increasing involvement with government health programs, rapid advances in therapeutic tools and methods, and all the other factors interacting to constantly change the practice of medicine, are presenting a continuing challenge to all phases of our scientific efforts. The role of the state medical association in scientific medicine is becoming progressively more difficult to fulfill, but it is to adequately meet these changes that the Council has dedicated itself. New avenues are being and must be explored in scientific publications, the annual meeting scientific program, postgraduate education and research.

The remainder of this report will consist of brief summaries of each broad subject area falling within the Council's responsibility.

Scientific Publications—During the latter part of 1965 and continuing into 1966, the monthly Journal, the Association's principal scientific publication, has undertaken a modernization and expansion program. Although publication of original scientific articles by FMA members has remained a basic purpose for its existence and has been continued, an "Association News" department has been developed to inform physicians of all sides of their organization's activities. To provide abstracted information concerning governmental programs and directives which are increasingly influencing the practice of medicine, a "Government News" department has been instituted. News of county medical society, specialty group, medical school and individual members' significant activities has been greatly increased. Thought-provoking editorials, often on controversial and current topics, are being solicited and published regularly. Occasional special issues featuring Florida medical history, individual county medical societies and medical schools, and other subject areas of interest to all physicians have been and will continue to be published.

Gradual, well thought out changes and improvements in The Journal's physical appearance have been made and

more may be expected, all with the objective of making The Journal a highly readable, useful reflection of Florida medicine.

During the period of this report, it is encouraging to note that along with an increase in scientific and editorial material in The Journal, advertising support also has been on the upswing.

Annual Meeting Scientific Program—The Committee on Scientific Work met twice for the purpose of planning the scientific program of the 1966 Annual Meeting. After considerable deliberation, it was decided to hold a combined scientific session with the Florida Pediatric Society concerning problems in the management of pulmonary diseases. Guest speakers were carefully chosen for their knowledge and work in different areas of the subject.

For the remaining half of the FMA scientific program, concise papers on a variety of topics were solicited from Florida physicians. An adequate number of papers was submitted to provide a good selection for the program.

All scientific sessions have been so arranged that there are no conflicts with other parts of the Annual Meeting program. Cash prizes will be awarded for the top three scientific exhibits, of which there will be 17, all but one presented by Florida physicians.

Postgraduate Education—In compliance with a recommendation of the House of Delegates in 1965, the Committee on Postgraduate Education undertook steps to establish closer liaison with the medical schools to improve continuing education programs for the state's practicing physicians. Tangible evidence of the medical schools' interest is the appointment within the past year of Dr. Thomas D. Bartley as assistant dean for postgraduate education at the University of Florida College of Medicine and the more recent designation of Dr. Jerome H. Modell to coordinate postgraduate activities at the University of Miami School of Medicine.

Various ways and means of coordinating postgraduate education programs were explored in depth. Study and experimentation are being conducted on new methods of making continuing education available to physicians throughout the state. Among such methods are two-way telephone, radio and television links between medical schools and local hospitals, traveling postgraduate teams from medical schools and regional scientific seminars. It is anticipated that specific proposals will be forthcoming in the near future.

Research—The primary activity of the Committee on Research has continued to be in an advisory capacity to the Florida Medical Foundation in screening and evaluating applications for research grants. As such, the Committee works closely with the Foundation's Board of Directors.

Recommendations:

That the Association's entire scientific program be strongly endorsed and strengthened.

Dr. Greenfield: "The Reference Committee considered the report of the Council on Specialty Medicine and recommends approval of the report as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

Council on Specialty Medicine

EDWARD W. CULLIPHER, *Chairman*

Council:

During the year the Council on Specialty Medicine met at which time the following items were considered with resulting recommendations which were favorably approved by the Board of Governors:

Recommendations:

- 1) **Prevailing Fee Concept Program.**—That study of the prevailing fee concept be approved and that FMA members be encouraged to participate in the survey project; and in doing so participants should indicate their comments and questions regarding matters not clear to them.
- 2) **Resolution of the Florida Society of Pathologists regarding cytology cancer smear test.**—That the resolution as reworded be approved by the Council on Specialty Medicine.
 "Whereas, the Council on Specialty Medicine of FMA recognizes the importance of exfoliative cytology in detection of uterine cancer, and believes that the most effective means to provide this service is by a physical examination by a physician with standard methods of exfoliative cytology; therefore,
BE IT RESOLVED: That the Council on Specialty Medicine of FMA cannot at this time endorse the technique of the 'vaginal irrigation' or 'do it yourself' kit as being adequate for the detection of cancer of the cervix or uterus; however, further scientific corollary study of this technique should continue in order to determine the validity of the 'vaginal irrigation' technique."
 The Board of Governors agreed with the Council that this method of cytology should not be approved.

Other recommendations by the Council were considered by the Board of Governors and were referred to the Committee on Fee Schedules.

Dr. Greenfield: "The Committee considered resolution No. 66-24 found in your delegates' packet and recommends that this resolution be amended and adopted."

Dr. Greenfield read the amended resolution in its entirety.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Resolution 66-24

General Practice

WALTER W. SACKETT JR., M.D., *Delegate
Council on Specialty Medicine*

Whereas it was the expressed intent of the 1964 and 1965 House of Delegates of the Florida Medical Association to form an ad hoc committee to investigate the shortage of general practitioners and the solution to this problem; and

Whereas the Board of Governors appointed an already standing and hence yearly changing committee to consider this problem; and

Whereas the original resolution indicated the Florida Academy of General Practice would be represented on this committee; and

Whereas, Under the present arrangement these members of the Florida Academy of General Practice are only observers; therefore, be it

RESOLVED, That this House of Delegates request the Board of Governors to appoint an ad hoc committee composed of two Deans, one from the University of Miami School of Medicine, and one from the University of Florida College of Medicine, two members of the Florida Medical Association's Committee on Medical Schools and two members of the Florida Academy of General Practice.

Dr. Greenfield: "The Committee considered resolution 66-28, University of Florida College of

Medicine, found in your delegates' packet and finds that the language of the resolution is vague and incorrect with respect to the intended purpose of the University of Florida Teaching Hospital; and further, that the financial cost for care of indigent and semi-indigent patients is a matter of local county responsibility except when state funds are available under other programs.

"Mr. Speaker, the Committee recommends that resolution 66-28 not be adopted."

Motion was seconded and carried.

Dr. Greenfield: "The Committee considered resolution 66-29, Florida Citrus Commission, found in your delegates' packet and recommends that this resolution be approved as written.

"Mr. Speaker, I move the adoption of this portion of the report."

Resolution 66-29

Florida Citrus Commission Polk County Medical Association

Whereas, Through the years the Florida Medical Association has enjoyed the cooperation of the Florida Citrus Commission, and

Whereas, This close relationship has benefited the field of medicine particularly in the realm of nutrition, and

Whereas, The Florida Citrus Commission has recently entered the field of medical publications with the periodical, "Nutrition Today"; therefore be it

RESOLVED, That the Florida Medical Association commend the Commission for its continued critical yet progressive attitude in the field of health and nutrition, and extend to the Commission best wishes for every success in its new venture.

Dr. Greenfield: "The Committee considered resolution 66-30, Continued Approval of Hospitals that Withdraw Specified Professional Services by Joint Commission on Accreditation of Hospitals, found in your delegates' packet and finds after hearings that there is no jurisdiction on the part of the Florida Medical Association on the matters reported in this resolution.

"Mr. Speaker, the Committee recommends that resolution 66-30 not be adopted."

Dr. Laudie E. McHenry Jr. of Brevard: "Those who are interested in this resolution believe that the Florida Medical Association does have an interest in professional services in hospitals and the effects on patient care related thereto. We think the reason for rejection of this resolution is not completely valid. In analyzing the situation of approval of hospitals by the JCAH, we found that if a hospital withdraws a service from its patients following inspection and approval by JCAH, there would be no further action by JCAH for approximately three years.

and at that time if it were indicated by the hospital that they were attempting to rectify the situation, they would have another year and after that, in all likelihood, a second year, thus making a five year period during which a specified and required service could be withdrawn. We are interested primarily in radiologic services and professional supervision of clinical laboratories. We think that probably in the "resolved" of this resolution, it should be modified to read that the 'Florida Medical Association requests the American Medical Association to urge the Directors of the Joint Commission on Accreditation. . . .'"

Dr. Samuel M. Day: "That is what I was going to say. The Reference Committee says the Florida Medical Association has no jurisdiction, but we can request the American Medical Association to ask the Joint Commission to do this."

Dr. Greenfield: "I would like to comment on the opinion of the Reference Committee without a long, drawn-out discussion. As the resolution was submitted to us, we thought it was completely inadequate as to a statement of the facts concerned and we specifically tried to learn what the facts were in the situation that was referred to which prompted the resolution. As far as we could ascertain, this was a situation which involved a hospital terminating a contractual arrangement with one or more pathologists. The resolution, however, says 'withdraw or cancel required profes-

sional services' and this would indicate that the patients within this hospital were then not getting the type of professional care and service that they were when the JCAH approved the hospital. The facts were that this particular hospital, as we understood it in the hearings, then continued to provide this service on the part of the same or other pathologists, but it was done on a private, outpatient basis, so that we did not think there was any violation or reduction in terms of health care to patients in the individual hospital referred to."

Dr. Paul N. Unger, of Dade: "I believe there are existing functional mechanisms operative within the policies and guidelines of the Joint Commission on Accreditation which could apply to this situation which has existed for some time. I would suggest that these existing functional mechanisms be brought to bear in each case rather than our taking a stand and trying to handle each specific instance which may come up. I would recommend a vote against this resolution and for the recommendation of the Reference Committee."

Motion was seconded and carried.

Dr. Greenfield: "Mr. Speaker, I move the adoption of this entire report."

Motion was seconded and carried.

The Vice Speaker, Dr. James T. Cook, assumed the Chair.

Report of Reference Committee No. II

Public Policy

Dr. George W. Morse: "Mr. Speaker, Mr. President, Members and Guests of the House of Delegates:

"Your Reference Committee gave careful consideration to items referred to it and makes the following report. The Reference Committee's recommendations on each item will be submitted separately and I respectfully suggest that each item be acted upon before going to the next.

"The Reference Committee considered the report of the Council on Allied Professions and Vocations and recommends the following amendment: The recommendations on page 22 of your Handbook be amended to read as follows:

"That the Florida Medical Association approve the position that the junior college curric-



Composing Reference Committee II were Drs. George W. Morse, chm., Laurie J. Arnold, Abbott Y. Wilcox Jr., Russell D. D. Hoover and Richard C. Clay.

ulum for the nurses' training program needs to be approved by the National League for Nursing.

"That the FMA take the initiative in establishing the State's education standards of all paramedical personnel; that these standards be instituted among the vocational schools, junior and senior colleges and other institutions qualified, and that these standards should be the guide established as the 'basis' for adequate training in all the paramedical fields.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Council on Allied Professions and Vocations

JESSE W. CASTLEBERRY, *Chairman*

Council:

The Council held two meetings during the past Association year, July 25, 1965, and February 13, 1966. The items referred to the Council by the Executive Committee became the major objectives for the year. The February 13 meeting was a progress report meeting on these and other items by the committees, summarized briefly as follows.

The Committee on Dentistry continued its liaison with the Florida State Dental Society. The Committee on Law continues working with the Florida Bar towards official adoption by the Florida Bar of the Florida Inter-Professional Medico-Legal Code. The Committee on Medical Assistants met with the Florida Medical Assistants Association and transmitted to the Council several problems which were confronting that Association. The Committee on Medical Technologists, charged by the 1965 House of Delegates with intensive study of Resolution 65-16 "Clinical Laboratory Science," has diligently proceeded in this area and intends to have a supplemental report ready for the 1966 House of Delegates. The Committee on Nursing held meetings with the Florida Nurses Association liaison committee and has become deeply involved with the nursing shortage problem. The chairman of this committee has met with various groups over the state and also on a national level seeking possible solutions to this very serious problem. The Committee studied in detail a survey of "Nursing Needs" which was sponsored by the Hospital Association in Texas. The details of this survey were presented to the Board of Governors and the survey was approved in principle, but the Florida Medical Association does not have the necessary funds to implement such a survey, so outside financial assistance is being sought.

The Committee on Pharmacy reported to the Council the Florida Pharmaceutical Association's position on the Hart Bill. Unless the Florida Medical Association supported a change in the American Medical Association's policy on physician ownership of pharmacies, they would support the Hart Bill. This was reported to the Board of Governors, who took a position to support the AMR's policy. Because the FMA would not conform to the pharmacists' demands, they elected to support the Hart Bill and recommended that through their monthly publication, pharmacists be asked to write their congressman in support of this bill. The Committee also has been active in Orange County and on the state level in a public relations direction to support the right of physicians to prescribe a specific medication, rather than compulsory generic prescribing. The chairman met with the Executive Committee of the American Physical Therapy Association in February 1966, then polled the members of the Committee for opinions and recommendations in regard to requests received by the American Physical Therapy Association, Florida Chapter. The Com-

mittee on Religion meetings included members of the clergy in programs with physicians on the topic of medicine and religion, which were held in several component counties. The Committee operated as individuals in their respective area.

The Committee on Veterinary Medicine's projects extend through more than a single year and complete results are usually pending. The committee members, who participated in the joint project, worked hard and a great deal was accomplished. New suture materials were utilized on both human and animal subjects, the results to be published near the end of this year. A lengthy project involving electron microscopic studies of nervous tissue tumors is only in its beginning. Genetic involvement in some congenital defects is a combined effort of two committee members. Preliminary studies achieved last year regarding lymphatic anatomy are now being utilized for clinical follow-up experiments. The Committee was also represented at the annual meeting of the Florida State Medical Veterinary Association in Orlando where mutual problems were discussed. The Committee on X-Ray Technicians has been in close contact with the Florida Society of Radiologic Technologists throughout the year and there have been no problems. We are supplying a speaker for their forthcoming annual meeting to be held in Jacksonville.

Recommendations:

That the Florida Medical Association approve the position that the junior college curriculum for the nurses' training program needs to be approved by the National League for Nursing.

That the Florida Medical Association take the initiative in establishing the State's education standards of all paramedical personnel; that these standards be instituted among the vocational schools, junior and senior colleges and other institutions qualified, and that these standards should be the guide established as the "basis" for adequate training in all the paramedical fields.

Dr. Morse: "The Reference Committee recommends the supplemental report of the Committee on Medical Technologists be approved with the exception of the following amendments to the principles:

"Principle III, add to the last sentence, 'as outlined in Bulletin HIM-4, March 1966.'

"Principle X, delete the last sentence.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded.

Dr. William M. Straight, of Dade: "I would like to speak to several items—in particular I would like three amendments to this report. I feel qualified to speak on this matter because I spent many hours during the year 1964 and 1965 with representatives of 40 different organizations who were interested in the practice of medical technology in our state and the laws that govern it. It was at my motion that the study for the past year was carried out after our action on it at this House of Delegates last year.

"The first amendment I would like to the supplemental report of the Committee on Medical Technologists is to amend it to read as one of the basic principles guiding our rewriting of the law that it be clearly stated that all laboratories in the state will come under the purview of this law

except the laboratory operated in the doctor's office for work on his own patients only, and except for laboratories that are operated in federal government hospitals. The reason for this is, one of the basic defects in our present law is that it covers only 62 laboratories out of more than 350 that exist in our state. Any laboratory operating in a hospital, whether under the care of a pathologist or a technician, or a nurse, or anyone else, just so long as it operates within the walls of a hospital, does not come under the purview of the present law. Unless we clearly enunciate this principle, I believe we will be in the same boat with the revised law."

Dr. Cook: "Dr. Straight, are you adding a principle?"

Dr. Straight: "Yes."

Dr. Millard B. White, of Sarasota: "Actually Principle III referring to the HEW regulations covers this particular principle. We do not object to it being repeated if you wish."

Motion was seconded and carried.

Dr. Straight: "My second motion springs from the report wherein Principle II states, 'The Florida Law on the practice of medical technology shall be under the supervision and control of the State Board of Medical Examiners.' I would oppose this and wish that it remain under the control of the Board of Examiners in the Basic Sciences. The reason is that the Board of Examiners in the Basic Sciences represents the other professions that are involved in the practice of medical technology; for example, it has a chemist on it, it has a bacteriologist on it, it has a pathologist on it, an anatomist and others. The State Board of Medical Examiners is composed completely of practicing physicians, and I think if we put this under the State Board of Medical Examiners, we will do a disservice to laboratory medicine.

"Therefore, I move that principle II be amended to read: 'The Florida Law on the practice of medical technology shall be under the supervision and control of the Board of Examiners in the Basic Sciences of the State of Florida.'"

Motion was seconded.

Dr. White: "The Committee on Medical Technology has spent almost two years reviewing these problems. We recommend this change because laboratory medicine is a part of the practice of medicine, not basic science; the results of laboratory medicine are used by physicians in the diagnosis and treatment of patients. Physician-

directed laboratories doing work on referred patients would be under the proposed law and they would prefer to deal with the Board of Medical Examiners. Hospital laboratories are included under the proposed law and physicians would have a greater voice in the standards for the operation of these laboratories. There is evidence that expansion by pressure from Medicare and other governmental health programs may well eventually include laboratory work done in physicians' offices on their own patients, and we would like to have a chance to say something in this matter. The Board of Medical Examiners is able to administer this proposal, and have expressed willingness to do so. The proposed law can be administered at least as effectively, and probably more so under the State Board of Medical Examiners and the cost would be essentially the same. An effective working arrangement already exists between the State Board of Health, which is involved in the inspection of laboratories under the proposed law, the Florida Medical Association and the State Board of Medical Examiners. This is well illustrated by other programs, including administration of the Narcotics law. The interests of nonphysician-directed laboratories and of non-medical laboratory personnel licensed under the law are adequately protected by broad representation on the advisory committee of nonmedical personnel which will be provided under the proposed law.

"Sequestration of a portion of the practice of medicine with control by lay and nonmedical personnel without advisory control by physicians is ill-advised at this time and not in the best interest of the patient. Further, if you pass this amendment, you close the door on the Committee on Medical Technology from even exploring this possibility. You must realize that these are only guidelines in order to develop a practical law on medical technology. We do not know what we will get when we get to Tallahassee; we may get very little of this. If you will read the report, the Board of Governors has the final say as to whether the Florida Medical Association will back any proposed law."

Dr. Eugene G. Peek Jr.: "Representing the State Board of Health and the Bureau of Laboratories, I would like to endorse the amendment of Dr. Straight."

Dr. Unger: "I can see both viewpoints. I wonder if it would be acceptable to both sides in this question, if we were to add under principle

II, after Florida, 'with advisory representation by the State Basic Sciences Board.' "

Dr. Straight: "This is not acceptable to me at all. Advisory boards are just advisory, and having served on a number of these I learned that they do nothing; they accomplish nothing."

Dr. Sanford Mullen, Council on Specialty Medicine: "I think the issue here is very clear. This amendment would take hospital laboratories, the radiologic laboratories and radioisotopes and possibly blood banks outside hospitals, or possibly even in hospitals, and put them under a lay board which has no necessary physician representation. We believe the interests of the nonphysician people will be well served by strong advisory committees. To separate us as pathologists—to separate the medical staff's responsibility for adequate laboratories—and put this under a lay board would be absolutely contrary to the interests of physicians and their patients. We cannot say too much in opposition to this amendment."

Dr. James J. Hutson, of Dade: "Earlier the State Board of Medical Examiners declined the single licensing board, and this laboratory board is going to have to encompass the entire practice of medicine, and to put this under the Board of Medical Examiners might not be to our best interest and might create some antagonism in some of the others or the feeling that we were invading their area of practice."

Dr. George S. Palmer, President-Elect: "I would like to express agreement with Dr. White and Dr. Mullen on this issue and also say that this has absolutely nothing to do with the rejection of the 'one board of medical examiners.' "

Dr. Hampton: "Although we have no resolution from this House, I would like to say that we have given serious consideration to, at the right time, abolishing the Basic Science Board."

The amendment was defeated.

Dr. Straight: "The final amendment that I have to offer to the supplemental report requires a little explanation. At the end of this report it states that the Committee on Medical Technologists will be happy to rewrite the present law and submit a proposed law to be taken to the legislature. I have no objection to this Committee doing it, but I would like to make a motion that if this Committee is given the responsibility to rewrite this law, the Committee be expanded so that some members of the Association other than the pathologists are represented, and not just in an advisory capacity. I realize the pathologists

desire to control laboratory medicine in the state and I understand their reasons, but the internists are the consumers of laboratory services and we should have a voice in the writing of this law. The Committee membership should not consist of five pathologists and one internist—it should be equitably distributed. There may be other specialties which would like to be represented and I think they should have a voice. My motion is that if the Committee on Medical Technologists of the Florida Medical Association is designated to rewrite the state law, that Committee shall be expanded to include representatives from other branches of the profession that have something to do with laboratory medicine."

Motion was seconded.

Dr. White: "We have no objection to this; we intended to do it anyway."

Dr. Straight accepted the suggestion that the Board of Governors should be asked to expand the Committee.

Motion carried.

Motion was carried to approve the supplemental report of the Committee on Medical Technologists as amended.

Supplemental Report

COMMITTEE ON MEDICAL TECHNOLOGISTS

Preamble

The Committee on Medical Technology, at the direction of the House of Delegates and the Board of Governors of the Florida Medical Association, has undertaken a study of the Florida Law on the Practice of Medical Technology (Chapter 483 F.S., 1955). Conferences have been held with representatives of medical technology groups, state agencies and other organizations concerned with this matter.

Furthermore, other state licensing laws in this field, Resolution 65-16 from the House of Delegates, and proposed rules and regulations of the United States Department of Health, Education, and Welfare have been studied. With the acquisition of this information, it has become abundantly clear that the present law is inadequate. It is in the public interest that we recommend an extensive revision of this law. It is our opinion, however, that it is not appropriate for this Committee to undertake to rewrite the law without the advice and counsel of competent legal and legislative authorities; therefore, we propose the following basic principles to be used as guide lines in the revision of the Law on the Practice of Medical Technology and the licensure and regulation of medical laboratories in the State of Florida.

Discussion

If it is the desire of the House of Delegates and the Board of Governors and if legal counsel is provided, the Committee on Medical Technology is prepared to rewrite the Florida law on the Practice of Medical Technology, with the cooperation of representatives of the State Board of Health, the State Board of Medical Examiners, the Board of Examiners in the Basic Sciences and the various medical technology groups.

and submit it to the Board of Governors for approval before offering it to the legislature for its consideration at the 1967 session.

Principle I

The Florida law on the practice of medical technology shall be in two parts:

- A. The licensing of medical laboratories including laboratory directors.
- B. The licensing of laboratory personnel, other than directors.

Discussion

Both the State of New York and the State of Illinois provide for the licensing of medical laboratories and of laboratory personnel in the same bill.

In the proposed regulations entitled, "Conditions for Coverage of Services of Independent Laboratories," the Department of Health, Education, and Welfare defines the qualifications of laboratory personnel as part of the conditions for licensing a laboratory.

Principle II

The Florida law on the practice of medical technology shall be under the supervision and control of the State Board of Medical Examiners of Florida.

Discussion

Since the Board of Medical Examiners has agreed to accept the administration of a revised law and the Board of Examiners in the Basic Sciences has indicated its willingness to relinquish this responsibility, there seems to be agreement on this principle by the respective state agencies.

It was noted that some other states, New Jersey for one, place the supervision of this law under the medical examining board.

It should be emphasized that the terms and details of the law must be broad enough to allow the State Board of Medical Examiners latitude in the administration of the law.

Principle III

Requirements for licensing of both laboratories and personnel shall conform as nearly as possible to the standards established by the United States Department of Health, Education, and Welfare as outlined in Bulletin HIM-4, March 1966.

Discussion

In order to qualify for payment for recipients of Medicare, independent laboratories must meet the regulations of the Department of Health, Education, and Welfare as outlined in "Conditions for Coverage of Services of Independent Laboratories." Since 30 to 50 per cent of all the clients of laboratories will be recipients of Medicare, it seems inconsistent that the State of Florida should have regulations governing both laboratories and their personnel that are different from those established by the Department of Health, Education, and Welfare.

Principle IV

Funds shall be adequately provided by the State for the administration of this law. Fees paid by registrants and/or licensees under this law shall not be prohibitive.

Discussion

New York cited as an instance where the law states that administration of the law shall be financed by the registration fees paid by registrants. This has meant that registrants must pay as much as \$500 to \$1,000 a year apiece to meet the high costs of administration.

Principle IV is an effort to place reasonable limitations on the fees required of registrants.

Principle V

Proper supervision of laboratories under this law shall include renewal of licenses on an annual basis and a formal inspection every one to three years. A program for the continuing evaluation of laboratory proficiency shall be established.

Principle VI

The qualifications of any inspector must meet or exceed those required for a laboratory director. An inspector must have qualifications at least equal to the laboratory director of any laboratory which he inspects.

Discussion

A law for the licensing of medical laboratories would require double licensure for physicians practicing laboratory medicine. The principle of double licensing has been tested in court in New York which said, in effect, that the state does have authority to license laboratories operated by licensed physicians.

The use of unqualified inspectors by any state agency would create an undesirable situation and defeat the entire purpose of the licensing law.

Principle VII

No medical laboratory licensed under this act shall send specimens to any laboratory outside of the State of Florida for examination unless such laboratory has been approved by and registered with the State Board of Medical Examiners of Florida, thus meeting the minimum standards for medical laboratories established by this act. When the specimen has been referred for examination to an out-of-state laboratory, the report shall bear or be accompanied by a clear statement that such findings were obtained in such other laboratory and shall specify its name and location.

Discussion

The licensure laws of the states of Illinois and New York both provide that the qualifications of laboratories shipping specimens and reports across state lines be equal to those of the state in which the patient resides.

Senator Javits of New York has introduced a bill in the Congress which would require the Surgeon General of the United States Public Health Service to approve laboratories shipping specimens and providing laboratory services in interstate commerce.

Therefore, there is considerable precedent for this Principle.

Principle VIII

This act shall be guided by the following principles with reference to the education of medical laboratory personnel.

- A. The State Board of Medical Examiners of Florida shall determine minimum standards of education required for admission to the examination.
- B. The State Board of Education shall be encouraged to provide adequate educational facilities for training of medical technology personnel.
- C. The law on medical technology shall not provide for accreditation of schools of medical technology.

Discussion

In general, state licensure laws do not give authority to any of the state agencies to license schools for training of medical technologists; however, these schools must be acceptable to the state agency charged with the responsibility of licensure. The American Medical

Association provides a voluntary accreditation program for schools of medical technology.

Principle IX

The State Board of Medical Examiners of Florida shall appoint two appropriate advisory committees to assist in the administration of the law:

- A. One shall concern itself with the licensure and regulation of laboratories.
- B. The other shall concern itself with the Licensure of laboratory personnel.
- C. These committees shall meet at least once a year.

Discussion

As far as we were able to determine, the licensed medical technologists and those practicing medical technology in the State of Florida have had little opportunity to provide consultation or guidance to the Board of Examiners in the Basic Sciences with respect to licensure of their profession. It is the desire of the various medical technology groups to provide a liaison to represent them in a licensure program.

If the State Board of Medical Examiners delegates authority to the State Board of Health to administer the law governing medical laboratories, the latter would of necessity require an active advisory committee to provide a pool of qualified personnel to assist in inspection and educational programs.

It is essential that both committees be active working committees in order to carry out an effective program for continual evaluation of laboratory proficiency and personnel qualifications.

Principle X

A Grandfather clause for laboratories which are currently licensed within the state should be included, but the laboratory license should expire automatically with a change in directors. New laboratories which do not meet these standards should not be licensed.

Discussion

As in all regulatory laws designed to upgrade the performance of those that it licenses, it is inevitable that eventually unqualified personnel and medical laboratories will be eliminated. Principle X provides a period of time during which individuals and laboratories will have to upgrade their standards to meet the requirements of the law.

Principle XI

The administration of this law shall be conducted in such a manner that properly qualified laboratory personnel will be encouraged to seek employment in the State of Florida.

Discussion

It is not the purpose of these regulations to establish a barrier at the state line for adequately trained individuals in the field of medical technology or laboratory medicine. Therefore, as provided in other laws of similar nature, reciprocity, temporary licensing and licensing without examination of individuals whose qualifications can be well established should be considered in the provisions of this law.

Principle XII

All laboratories in the State of Florida will come under the purview of this law except the laboratories operated in the physician's office for work on his own patients only and except for laboratories that are operated in federal government hospitals.

Dr. Morse: "The Reference Committee considered the report of the Council on Medical Services

and recommends it be approved as printed in the Handbook, with the exception of recommendation #5 on page 23, which should be referred to the Council on Medical Education and Hospitals, and the deletion of recommendation #12, page 23 of the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Council on Medical Services

IRVING E. HALL, *Chairman*

Council:

During the period covered by this report, the Council held two formal meetings: August 8, 1965 and February 13, 1966. The former meeting, held in Orlando, was devoted largely to review and planning of the individual committees' programs; the latter, held in Tampa, to consideration and preparation of recommendations to be included in the Council's 1965-66 annual report.

The Council on Medical Services encompasses probably the largest variety of detailed programs and activities falling within the responsibility of any one council of the Association. Most of the Council's 13 committees initiate and implement comprehensive programs in their areas of interest. It is in the inevitable overlapping of many of these areas that the Council fulfills perhaps its most useful function. Even so, there is such a wide scope of interests represented that the Council at times appears to serve only as a paper organization.

Although each of the following recommendations was adopted by the Council as a body in the form presented, the originating committee or other source is shown to facilitate reference for further background information.

Recommendations:

1. That the Woman's Auxiliary to the Florida Medical Association be requested to ask its chapters to undertake the active promotion and establishment of local homemaker services and comprehensive home care programs.

2. In order to bring about and maintain higher standards of care in nursing homes through frequent inspection and enforcement of regulations, the State Board of Health be urged to provide physicians and hospitals with certification of all nursing homes by degree and type of care available.

3. That it be recommended to the State Department of Education and State Board of Health that representatives of the Florida Pediatric Society and the Florida Academy of General Practice be added to the School Health Medical Advisory Committee to the two state agencies.

4. That a revised abortion law utilizing principles approved in a model law by the American Bar Association and the American Medical Association be introduced in the 1967 session of the Florida Legislature.

(5. That hospital regulations pertaining to human sterilization be revised and updated.)^{*}

6. That the Multi-County Maternal and Infant Care Project, sponsored by the State Board of Health and the University of Florida College of Medicine, be endorsed in principle.

7. That a pathologist be added to the Committee on Maternal Health in an ex-officio capacity.

8. That the state and county medical society Selective Service Advisory Committees be held at the same membership permanently insofar as practicable.

9. That public schools be urged to limit food and drinks available to pupils on the school campus to the type "A" lunch, milk and full strength fruit juices; that nutritionally

^{*}Not approved—referred to Council on Medical Education and Hospitals for study.

adequate school food service be provided in all schools, and that the school curriculum emphasize nutrition education.

10. That previous (1965) venereal disease recommendations be reaffirmed; that counties already having venereal disease education in the school curriculum be encouraged to continue and counties not having such education be urged to adopt it, and that county medical societies be urged to initiate venereal disease educational programs for their members and for teachers in their local schools.

11. That a bill be introduced in the 1967 session of the Florida Legislature which would establish a statewide pasteurization law outlawing the sale of raw milk.

12. That approval be given to the addition of measles vaccine, for indigents only, to the State Board of Health immunization program under existing Florida Medical Association policies.

13. That support be given to the voluntary statewide PKU testing program and that cooperation of all physicians and hospitals be encouraged.

14. That the Florida Medical Association oppose the establishment of a state mental hospital in Hernando County.

15. That legislation permitting "emergency involuntary hospitalization of the mentally ill or suspected mentally ill with good cause shown" be re-enacted during the 1967 session of the Florida Legislature.

Dr. Morse: "The Reference Committee considered the report of the Council on Voluntary Health Agencies and recommends that it be approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Council on Voluntary Health Agencies

MASON ROMAINE III, *Chairman*

Council:

During the period covered by this report, the Council on Voluntary Health Agencies was concerned with a wide variety of subjects and activities aimed at perfecting and implementing the Association's relatively new program in this field, a program now six years old. Formal Council meetings were held May 29, 1965, and January 22, 1966. The latter meeting included the Council's annual joint conference with the executive directors of the recognized Florida voluntary health agencies. The following brief summary of the Council's activities is reported by general subject.

Criteria for Recognition—After considerable study, the Council recommended to the Board of Governors that a twelfth criterion for official Association recognition be added to the previous eleven which are utilized in evaluating applications from statewide voluntary health agencies. Approved by the Board in September 1965, the new criterion reads as follows: "Must be ethically sound and in operation long enough to be evaluated." The Council also recommended that the recognized agencies be authorized to use the following statement, subject to annual reevaluation and possible withdrawal at any time: "Officially recognized by the Council on Voluntary Health Agencies of the Florida Medical Association." This recommendation was subsequently approved by the Board of Governors.

Recognized Voluntary Health Agencies—As in past years, the programs of the ten recognized agencies were reviewed and no grounds were found for discontinuance of recognition of any individual agency. Pending applications from several agencies were studied carefully and official recognition was recommended for one (National Multiple Sclerosis Society). The following organizations currently are recognized:

Florida Chapter, Arthritis Foundation
Florida Society for the Prevention of Blindness

Florida Division, American Cancer Society
United Cerebral Palsy of Florida
Florida Society for Crippled Children and Adults
Florida Heart Association
Florida Association for Mental Health
The National Foundation
Florida Association for Retarded Children
Florida Tuberculosis and Respiratory Disease Association

Florida Voluntary Health Agencies Coordinating Committee: Close liaison was maintained with the executive directors of the recognized agencies and with their own liaison organization, the Florida Voluntary Health Agencies Coordinating Committee. As indicated earlier, a portion of the Council's January meeting was set aside for a joint session with the directors in which many problems were openly discussed to the benefit of all parties concerned.

The Coordinating Committee sponsored an educational "Institute for Voluntary Health Agencies" which was held August 26-28, 1965, in Miami Beach. Several members of the Council participated in this successful meeting as speakers or discussion group leaders. Another such institute is being planned for August, 1966, and the Council has offered its wholehearted cooperation.

Plans also are under way to increase the formality of the Coordinating Committee's structure in order to expand its scope of activities. The progress of this unique and useful mechanism is being closely observed by medical associations and voluntary health agencies in other states.

Charitable Solicitations Act—Florida's Charitable Solicitations Act was passed by the 1965 session of the Florida Legislature. It became effective September 1, 1965. This model law was the result of long term efforts by the Council and others interested to obtain a workable state law which would provide protection to Florida citizens donating to charitable causes while not causing unreasonable hardship to legitimate charitable organizations. A considerable debt of gratitude is owed the Secretary of State and key members of the legislature who took leadership in drafting the legislation and guiding it to final passage. The Council is represented on the Charitable Solicitations Act's advisory committee by two members appointed by the Secretary of State.

AMA Council on Voluntary Health Agencies—Close liaison has been maintained with the American Medical Association Council on Voluntary Health Agencies. Valuable information is exchanged between the two groups. This relationship continues to be aided by the Florida chairman's membership on both councils.

Joint Accreditation of Voluntary Health Agencies—Considerable discussion has been held regarding the feasibility of establishing some type of joint accreditation mechanism for voluntary health agencies. The Florida Voluntary Health Agencies Coordinating Committee has appointed a subcommittee to study the matter and report its findings to the Council.

Postgraduate Programs of Voluntary Health Agencies—To improve dissemination of information on postgraduate programs for physicians sponsored by voluntary health agencies, the Council will request each recognized Florida voluntary health agency to supply the Association on a continuing basis with information on such planned or scheduled programs.

County Medical Society Activities—During the coming year, it is the Council's plan to place heavy emphasis upon encouraging the activation of county medical society voluntary health agency committees. Materials describing the state and national programs containing specific suggestions and guidelines for local activities will be furnished to each county medical society. The Council also hopes later to invite local chairmen to meet with it to further liaison and communications.

Dr. Morse: "The Reference Committee recommends approval of resolution 66-11, Motorcycle Safety Program, as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Resolution 66-11

Motorscooter, Motorcycle and Motorbike Safety Program Marion County Medical Society

Whereas, There is an epidemic of injuries and deaths resulting from motorscooter, motorcycle, and motorbike accidents spreading throughout our nation, and

Whereas, These accidents involve the younger, less experienced individuals, and

Whereas, These injuries are of a severe nature due to the basic instability and lack of protection of these vehicles, therefore be it

RESOLVED, That the Florida Medical Association publicize the potential dangers of these machines, and be it further

RESOLVED, That the Florida Medical Association advocate an instructional program and safety equipment, including protective helmets and "crash bars," and support legislation making these mandatory.

Dr. Morse: "The Reference Committee recommends that resolution 66-25, Compulsory Reporting of Communicable Disease, which was in your delegates' packet, not be adopted for the following reasons: It would require laboratories, firms or corporations which may diagnose, suspect or test, to report to the State Board of Health directly instead of reporting to the physician involved. Also, this resolution calls for compulsory reports on all communicable diseases.

Dr. Cook: "The motion is, not to approve resolution 66-25."

Motion seconded.

Dr. Jesse W. Castleberry, of Orange: "The legislative committee of the Orange County Medical Society, in conjunction with the Public Health Officer, composed this resolution. The purpose was to try to get better reporting of cases of venereal disease. The objections which have been noted certainly are important. For this reason, I propose an amendment to this resolution and ask that it be adopted as amended. The amendment would begin at the point where it says 'resolved,' to read: 1. That the Orange County Medical Society deems that sufficient facts exist that compulsory reporting of communicable diseases as required by law be fully supported by the Florida Medical Association, and that an appropriate standing committee be given the task of seeking ways to better implement reporting of venereal disease."

Dr. Evans: "All that is being accomplished is to say that we ought to enforce the law. It is

superfluous, rather vague; there are laws sufficient right now to cover the situation, and we are just doing what many of our state legislatures do—cluttering up our books with resolutions which have no meaning or effect. Therefore, I am opposed to it, not in principle, but because of the fact that we do not need it."

Dr. Flipse: "Before we approve this amendment, you should look back at the law and you will find a very bad law already on the books. I do not think a laboratory should report false positives and report information it receives on your patients. The law says quite plainly, but the Board of Health chooses to ignore, I think wisely, that laboratories should report serologies, TB tests and other things, but they do not, and the Health Departments do not enforce it. Only the physicians of Florida can make diagnoses and they should fight very hard against this. Now it is on TB and venereal disease; it could be soon on all reportable disease. If you approve this amendment, you are putting teeth in a bad law which opens up part of your practice to federal, state and other agencies, and we probably should amend the present law and take out the requirement that laboratories have to take over our responsibilities of reporting disease."

The amendment was defeated.

The motion to disapprove the resolution was carried.

Dr. Morse: "The Reference Committee recommends that resolution 66-32, Licensing of Commercial Insurance Coverage of Blood Transfusion, which was in your delegates' packet, be amended and adopted with the following change: In the last paragraph change 'Leon-Wakulla-Jefferson County Medical Society' to 'Florida Medical Association.'"

"Mr. Speaker, I move the adoption of this portion of the report."

Motion seconded.

Dr. Nelson H. Kraeft, of Leon: "In order to avoid any confusion in the principle of this resolution, which is in opposition to blood insurance policies, we would like to further amend the resolution to delete in the first paragraph the phrase 'or by other monetary means,' and in the last paragraph, third line, 'or any other monetary means of coverage.'"

Motion was seconded.

Dr. Mullen spoke in favor of these amendments.

Motion was carried.

Motion was carried to adopt the resolution as amended.

Resolution 66-32

Opposing Licensing of Commercial Insurance Coverage of Blood Transfusion by State of Florida

Leon-Wakulla-Jefferson County Medical Society

Whereas, The coverage of blood indebtedness by commercial health or blood insurance policies usually results in settlement by currency exchange rather than voluntary blood replacement, blood donation, and

Whereas, Settlement by currency rather than voluntary replacement by blood diminishes stocks of donor blood and thus necessitates purchasing of bloods from individuals and commercial sources, and

Whereas, Purchased blood more often transmits disease than do bloods from voluntary donors, and

Whereas, Purchased bloods usually result in a lowering of general quality of blood for transfusions purposes, and

Whereas, Purchasing of blood usually results in increased charges to patients for transfusion services; therefore, be it

RESOLVED, That the Florida Medical Association hereby declares opposition to commercial health or blood insurance, which provides monies for settlement of blood indebtedness.

Dr. Morse: "The Reference Committee recommends that resolution No. 66-33, Upgrading Paramedical Personnel, not be adopted because it has been previously covered by the Council on Allied Professions and Vocations.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion seconded and carried.

Dr. Morse thanked the members of the Association who appeared before the Reference Committee and the Committee members for their dedicated efforts.

Dr. Morse: "Mr. Speaker, I move the adoption of the Committee's entire report as amended."

Motion seconded and carried.

The Speaker, Dr. Franklin J. Evans, resumed the Chair.

Report of Reference Committee No. III

Finance and Administration

Dr. Jere W. Annis: "Mr. Speaker, Mr. President, and Members of the House of Delegates:

"Your Reference Committee on Finance and Administration has considered each of the items referred to it and submits the following report. The Committee's recommendation on each item will be submitted separately and we request that each item be acted upon separately before proceeding to the next.

"The Reference Committee considered the report of the Board of Governors, H. Phillip Hampton, Chairman, on page 26 of the Handbook, and commends the Board on the extent and the intensity of its activities during this past year.

"Major Activities, page 26—The audited financial statement for the year 1965 and the budget for the year 1966 were reviewed and approved. The complete report is available for review by any member of the Association. The Board is commended for its sound fiscal policies and current financial position.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Dr. Annis: "Page 27, third paragraph, Recognition—the selection of the recipient of the 'A. H. Robins Company Award for Outstanding Com-



Serving as Reference Committee III were Drs. Jere W. Annis, chm., William A. Van Nortwick, Charles R. Sias, James A. Winslow Jr. and Nelson Zivitz.

munity Service by a Physician,' presented at the first meeting of the House of Delegates, was endorsed by the Reference Committee, and the Board of Governors is commended for its discriminating and unbiased selection of Dr. James A. Long Jr., an outstanding Florida physician and member of this Association as the well-deserving recipient of this statewide award.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Dr. Annis: "Referrals by the House of Delegates, page 27—the Committee carefully consider-

ed the unanimous recommendation of the Board of Governors' . . . that resolution 65-10, One Board of Medical Examiners, be disapproved,' and after hearing extensive testimony, reviewing the entire files of the Association's survey, and discussing the matter at length in executive session, finds itself in complete accord with the purposes and intent of the resolution, but unanimously concurs in the Board of Governors' recommendation that resolution 65-10 not be adopted. It is the Committee's opinion that such a Board would not produce a significant improvement in the overall medical care in this state, that it would dilute the professional excellence of the examining body for medical practitioners, and that it would place the Board, composed largely of physicians, in the position of licensing cultists and differentiating between the various grades of cultists in this state. It is the opinion of the Committee that a sharp line must continue to be drawn between doctors of medicine and practitioners of the various cults and that it is not the medical profession's responsibility to interfere with the patient's choice of cultists or to attempt to improve the quality of quackery.

"In addition, we think that the establishment of a single Board of Medical Examiners to apply to all branches of the healing arts is not practical at this time and that it would not further enhance the purposes served by the Basic Science examinations enacted with great difficulty by the legislature through the efforts of this Association many years ago.

"In summary, it was thought that the disadvantages of the creation of such a Board at this time would far outweigh the possible advantages which a single Board, offering representation to osteopathy, chiropractic, chiropraxy, etc., would invoke.

"The Committee recommends approval of the Board of Governors recommendation that Resolution 65-10 not be adopted.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion seconded.

Dr. Russell B. Carson, of Broward: "Speaking for the Broward County delegation, we take cognizance of the fact that in the beginning of this discussion by the Committee there was complete accord with the purposes and intent of the resolution, and we take heart from that. We are, too, aware of the fact that this may not be the opportune time to accomplish a one board organiza-

tion, but we do urge that this body not summarily dismiss consideration of this as a possibility, but that they provide a means of continuing study of the difficulties which the Committee has recognized.

"Therefore, we would request that this body accept an amendment that the subject of 'One Board of Medical Examiners' be referred to an appropriate committee for continuing study of feasibility. In parenthesis we might suggest that it be either the Board of Governors or the Judicial Council."

Amendment was seconded.

The voice vote was not conclusive and the Chair asked for a standing vote.

The amendment was carried by a vote of 93 to 59.

Motion as amended was carried.

Dr. Annis: "Council and Committee Reports, page 28—the Committee recommends approval of this section of the Board's report as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Dr. Annis: "Nominations, page 28—the Reference Committee congratulates the Board of Governors for its selection of Dr. Chas. J. Collins of Orlando as the recipient of the Association's Certificate of Merit and commends to each component society the study of the significant contributions made by this outstanding physician to his county, state and national organizations. It is to be hoped that each component society of this organization may in the course of years produce such an unselfish, dedicated and outstanding doctor.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Dr. Annis: "Board Actions of Importance, page 29—these actions were considered by the Reference Committee and are approved with the following amendments:

"Fifth paragraph, General Session: It is recommended that the wording be amended to read ' . . . The Board requested that the President's guest speaker's address at the General Session during the Annual Meeting be designated the Abel Seymour Baldwin Memorial Lecture,' as recommended by the Committee on Archives on page 36 of your Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

"Sixth paragraph, Blue Shield, and the last paragraph, page 30, Medicare: The actions concerning Blue Shield and Medicare were considered together. Lengthy testimony, most of which was concerned with the shifting of responsibility of decision, was heard in this regard. No significant concrete suggestions were made to your Reference Committee regarding the solution of this problem. Your Committee is aware of the complexity of the problem as well as its shifting and unstable characteristics, particularly in regard to changing governmental regulations and demands. It is cognizant of the lack of comprehension and information in depth on this question by the majority of this House, and is confident of the dedication and the integrity of our governing Board. Consequently, it is your Committee's recommendation that the ultimate decision regarding the recommendation as to participation by Blue Shield as the carrier for Medicare in Florida rest with the Board of Governors in consultation with the Board of Directors of Blue Shield of Florida, Inc. In addition, should withdrawal by Blue Shield from any governmental contract into which it might have entered in this regard seem to become advisable at any future time, it is recommended that this decision also be made by the Board of Governors in the same manner.

"It is our conclusion that, other things being equal, if the demands made by the government are not inimical to the principles and policies of Blue Shield of Florida, Inc. and if they will not jeopardize the close and compatible relationship between Blue Shield of Florida, Inc., the Florida Medical Association, and the physician-patient relationship, Blue Shield be encouraged to be our intermediary with the federal government. The final decision in this regard, however, is to be left to the Board of Governors of this Association. This recommendation is to be an expression of intent, realizing that there will be a fiscal intermediary in any event, and that unless it jeopardizes our previously compatible association with Blue Shield, this agency would be preferable to a commercial carrier or a governmental agency.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded.

Dr. Zellner: "Because of the very bad publicity which not only Blue Shield but also the medical profession would get if on June 30 we found we were faced with an unacceptable con-

tract and have to ask Blue Shield to withdraw as fiscal administrator, I would suggest as a part of this report that we inform the Social Security Administration through Blue Shield that at the present time its requirements would be unacceptable to us, so that modifications which could take place within the next six weeks could be accomplished. I think it is important for it to know that we could not accept the principles which it has enunciated at the present time."

Dr. Evans: "I think the Committee's report would leave all of this to the Board of Governors."

Dr. Joseph A. Shelley, of St. Johns: "I would like to state very briefly that I do not believe we should think that we can control the politicians in Washington, and I think with the Blue Shield of Florida making itself an arm of the federal agency, it will lose the freedom that it might have, and we should all take cognizance of the fact that we are losing our freedoms. I do not think you can trust them and I am opposed to this."

Dr. Walter W. Sackett, of Dade: "On page 5 of the Committee report, second paragraph, it speaks of a number of relationships, but I think it omits the most important one. I move that it be included—'and the patient-physician relationship' which to me is the most important relationship of all. If this is jeopardized, we are in real trouble."

Motion seconded and carried.

Dr. Walter J. Glenn Jr., of Broward: "I would like to raise an objection to the Board of Governors making the final decision to sign a contract with the government without the House of Delegates having the opportunity to vote. I move that the final decision be left to the House of Delegates."

Dr. Evans: "I think you are out of order. The Florida Medical Association does not sign any contract with the government. Blue Shield would sign the contract—not the Board of Governors or the Florida Medical Association."

Dr. Glenn: "My motion is that the final decision on signing a contract with the government be left in the hands of the House of Delegates."

Dr. Evans: "I think this is still wrong as Blue Shield would sign the contract."

Dr. Glenn: "The report says that the Board of Governors will make the final decision. I will move that in the report the 'House of Delegates' be substituted for 'Board of Governors.'"

Dr. Carson: "I think we should put our trust in the Board of Governors to perform for us in

this capacity in conjunction with the carrier designated for our state, Blue Shield. I communicated the information as soon as we had a copy of the contract to your president, who talked this over with the Board of Governors, and I think that at the time of negotiations representatives from the Board of Governors, together with legal counsel from the Florida Medical Association, should be sitting at the bargaining table. This should be a joint action when the physicians of the State of Florida are committed to perform for the Medicare act and it should be one which has been agreed to by representatives of Florida medicine.

"About three weeks ago when I was in Memphis, a group from Atlanta came to me and asked what they could do in the Atlanta area to make a contact with the carrier or the intermediary in that area, and the Memphis group did the same thing. In both instances the fee schedule had been made up in advance of any consultation with medicine in those areas. There had been no contact between the intermediary and medicine of that area. Now Blue Shield is putting itself at your disposal and the Florida Medical Association has full control over the actions of Blue Shield in this area. Let us keep that and work side by side in the signing of this contract. But we should, and must delegate that activity to the Board of Governors."

Dr. Edward L. Cole Jr., of Pinellas: "I serve as a member of the Board of Directors of Blue Shield and I would like to assure the House that in my opinion there is not a single physician member of the Board of Directors of Blue Shield or a single lay member, who would vote to sign a contract with the federal government if their interpretation is that this would make Blue Shield an arm of the federal government."

Dr. Sackett: "I recall at the Blue Shield meeting that the president of the Blue Shield Board admitted they had made a gross error in issuing 70,000 supplementary contracts in part B. Certainly if they could make one error, they could make another. I would be in favor of Dr. Glenn's motion. At various times we have travelled to Jacksonville to debate at special called meetings of the House of Delegates on far less important matters."

Dr. Shelley: "I believe most physicians have indicated through the years that they are opposed to Medicare. It seems that since it became law we are drifting away from the stand that we took.

This is not said in a derogatory manner to our leadership on Blue Shield or the Board of Governors, but I believe to give aid and comfort to our enemy is bringing about the destruction of the free practice of medicine in this country. In my home county we have almost to a man decided not to participate in Medicare. We have refused to form a utilization committee for our hospital, because we think this program is inoperable and through this utilization committee, which will make our physicians an arm of the federal agency, they will put the monkey on our back when the program fails which many of us suspect it will do. I would like to speak in support of Dr. Glenn's amendment that this House be given the last word on this."

Dr. Straight: "I ask us to think clearly. I do not think it is sensible or practical for this big body to try to make decisions that have to be made quickly. If we got them together they still could not make up their minds judging from the discussion today."

Dr. Glenn's motion was defeated.

Motion was carried to approve the report of the Reference Committee as amended.

Dr. Annis: "Ninth paragraph, Workmen's Compensation: The Reference Committee recommends an amendment in the last sentence of this paragraph inserting the word 'diagnostic' before 'radiology.' The Committee commends the positive action of the Board of Governors in dealing with the Florida Industrial Commission and emphasizes to this House that at this time no approved Workmen's Compensation fee schedule exists in the State of Florida.

The Committee also commends the Board for the favorable outcome of its negotiations with the Division of Vocational Rehabilitation, in the acceptance by this body of a conversion factor of 5.0 across the board on the basis of the 1962 Relative Value Studies, and the acceptance of this same schedule by the Office for Dependents' Medical Care.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Dr. Annis: "Page 30, second paragraph, Medical Assistance for the Needy—inasmuch as the subject of this action was referred to Reference Committee No. IV in the form of a resolution, no action was taken on this portion of the Board of Governors' report.

"Page 30, sixth paragraph, Heart Disease,

Cancer and Stroke—the Committee recommends correction of a typographical omission in the last sentence, ninth line, of this paragraph, to read ‘. . . Florida Chapter, American Cancer Society. . .’ and on.

“Page 31, recommendation No. 1, the Reference Committee points out a typographical error occurring in the paragraph beginning, ‘The Council on Allied Professions and Vocations,’ and recommends that the word ‘Podiatry’ be deleted, inasmuch as there is no committee on Podiatry, whose recognition was withdrawn by this Association in 1964.

“Mr. Speaker, I move the adoption of this portion of the report.”

Motion seconded and carried.

Dr. Annis: “Mr. Speaker, this Reference Committee wishes to heartily endorse the recommendation of our AMA Delegates in nomination of Dr. Homer L. Pearson for re-election to the AMA Board of Trustees. We wish to express the appreciation and commendation of the entire Association to this member, who more than any other in the entire history of the Florida Medical Association has devoted his time, his talents and his professional life to the unselfish and overall benefits of organized medicine on the state and the national levels. We are indebted to this fine gentleman of medicine and to his constant dedicated efforts toward the improvement of our profession.

“Mr. Speaker, I move the adoption of this portion of the report, with a standing vote of commendation for Dr. Pearson by the House.”

Dr. Straight seconded the motion and commented that the Dade Delegation deeply appreciated his services as president of the Dade County Medical Association and of the Florida Medical Association and his long service on the Board of Trustees of the American Medical Association.

The Speaker stated that a vote was not necessary since the applause and the standing ovation were evidence of approval.

Dr. Annis: “The Reference Committee considered the reports of Subcommittees of the Board on Inter-American Relations, Quackery and Venomous Snake Bite and recommends approval of these reports as printed in the Handbook.

“Mr. Speaker, I move the adoption of this portion of the report.”

Motion was seconded and carried.

Dr. Annis: “Mr. Speaker, I move the adoption

of the report of the Board of Governors as amended.”

Motion was seconded and carried.

Report of The Board of Governors

H. Phillip Hampton, Chairman

The Board of Governors held four meetings during the Association's administrative year. They were held on April 25, 1965, September 23-24-25, 1965, January 15, 1966 and April 3, 1966.

The over-all activities of the Association continued to increase during this year. The greatest increase in activity was the result of the passage of Public Law 89-97, Medicare, and Public Law 89-239, the Heart Disease, Cancer and Stroke legislation. To provide additional coordination and leadership in these areas, the Board of Governors appointed a special Task Force to advise regarding implementation and application of Medicare, Heart Disease, Cancer and Stroke, and the Office of Economic Opportunity. The Task Force is composed of the President; President-Elect; Immediate Past President; Chairman, Council on Legislation and Public Agencies; Chairman, Council on Medical Economics; Chairman, Council on Medical Education and Hospitals; Chairman, Council on Medical Services; Chairman, AMPAC; Chairman, National Association of Blue Shield Plans.

The Chairman would like to take this opportunity to thank each and every physician who has given of his time and energies during the year to the benefit of our Association. It has been a great pleasure and very rewarding for your Chairman to have had the opportunity of being associated with these dedicated physicians.

Major Activities

Annual Meeting—The Board approved the format for the 1966 annual meeting and the scientific program as submitted by the Committee on Scientific Work. A new format has been developed for the annual meeting this year with the hope that it will provide a more efficient, organized and interesting meeting for the membership.

Presidents' and Secretaries' Conference—The Eighth Annual Conference of Presidents and Secretaries of County Medical Societies was held in January 1966 in Orlando. Again this year the purpose of the conference was to orient the officers of the county medical societies regarding major programs and activities of the Association to better enable their programming and implementation at the county level. The attendance was excellent with over 90% of FMA membership represented by their county society officers.

Financial Statement and Budget—The Board carefully reviewed the financial statement prepared by the Secretary-Treasurer and the Executive Director, and the Auditor's statement prepared by the Association's certified public accountant for the Association's fiscal year which was the calendar year of 1965. In 1965, the Association had an income from all sources of \$311,578; total expenses incurred, (including an inventory adjustment) were \$270,891, for a net excess of income over expenses of \$40,687. The Board approved an annual operating budget for the calendar year 1966 in the amount of \$300,000 +, which included \$25,000 for reserve and property amortization. In compliance with the By-Laws, this budget was presented by the Executive Director after consultation with the Secretary-Treasurer, it was reviewed by the Executive Committee and approved by the Board of Governors and was based on an anticipated income of \$300,000. Copies of the CPA audit are on file in the Association's office and available for review to members of the Association.

Appointments—On April 25, 1965, the Board appointed Francis T. Holland, M.D. as an AMA delegate to serve on the Board of Governors; Leo M. Wachtel, M.D., as the State Board of Health delegate to the Board of Governors; approved appointment of Samuel M. Day,

M.D. as Public Relations Officer; appointed Warren W. Quillian, M.D. as the optional member of the Executive Committee; reappointed the members of the Committee on Research with Karl B. Hanson, M.D., as Chairman; reappointed Thad Moseley, M.D. as Editor and accepted the Editor's nomination of John M. Packard, M.D. and Oscar W. Freeman, M.D. as Assistant Editors; appointed Jack Q. Cleveland, M.D., as the Assistant Editor from the Board of Governors; reappointed the subcommittees on Inter-American Relations, Quackery, Venomous Snake Bite, and appointed an Investment Plan Committee.

Recognition—The Board reviewed the nominations received from the county medical societies and selected the recipient for the A. H. Robins Company Award "for outstanding community service by a physician," to be presented at the first meeting of the House of Delegates, May 12 (Award nominations will be included in the delegates' packets).

Referrals by House of Delegates

The Board reviewed Resolution No. 65-10, "One Board of Medical Examiners," referred by the House of Delegates. Representatives of the Broward County Medical Association appeared before the Board in support of this resolution. The Board then contacted 20 states who currently have one Board for an opinion from both the Board of Examiners and the state medical association and the results of this survey were carefully reviewed. The Board noted that one stated purpose of having one board was an attempt to up-grade medical care and the survey did not indicate that this was accomplished in these 20 states.

Recommendation

The Board unanimously recommends that Resolution No. 65-10, "One Board of Medical Examiners," be referred to the appropriate committee for continuing study of feasibility. (Either the Board of Governors or the Judicial Council.)

Resolution No. 65-6 regarding the Australian National Scheme was referred to the Board of Governors by the House of Delegates. The Board unanimously agreed that the Social Security Amendments of 1965 have made the Australian National Scheme obsolete insofar as the position of medicine in the U.S.A. is concerned and, therefore, this subject should not be studied by the Board of Governors.

The House of Delegates adopted a recommendation of the Reference Committee in conjunction with Resolution No. 65-3, that tobacco ads should not be accepted in The Journal, nor should exhibit space be sold to tobacco companies. Your Board noted that this was an entirely new subject not related to the content of Resolution No. 65-3 and the House was in error in accepting this recommendation of the Reference Committee. Therefore, the action was unconstitutional and invalid; however, the Board has complied with this directive of the House.

All other resolutions adopted by the House were referred to the appropriate Council and Committee for implementation. The individual actions are reported in the respective Council reports.

Council and Committee Reports

The Board had the opportunity and the privilege of working closely with the Councils and Committees and in coordinating their activities and implementing the policies of the House of Delegates. The Board on April 3 carefully reviewed and edited all Council and Committee reports to be transmitted to the House of Delegates in the Delegates' Handbook. The complete reports as submitted by the Councils and Committees will be available at the Reference Committee meetings. Specific actions regarding recommendations of the Councils during the year are as follows:

Maternal Health—Approved the recommendation to establish standing committees of Maternal Health by each county medical society.

State Legislation Workshop—Approved the establishment of a system of key contact physicians for state

legislators and to sponsor a legislative workshop for representatives of the county medical societies.

Nominations

Certificate of Merit—Your Board recommends that Charles J. Collins, M.D., of Orlando, be awarded the Association's Certificate of Merit. (Complete nomination will be included in the Delegates' packets.)

Committee on Membership and Discipline—As provided for in the By-Laws, the Board of Governors nominates the following physicians for those terms expiring in 1966:

District 1	
J. Wayne Hendrix, M.D., Port St. Joe	1970
District 2	
Thomas M. Irwin, M.D., Jacksonville	1970
District 3	
Harold Rand, M.D., Miami	1970
District 5	
John J. Cheleden, M.D., Daytona Beach	1970
District 6	
William H. Proctor, M.D., West Palm Beach	1970
District 7	
John M. Butcher, M.D., Sarasota	1970

Blue Shield Board of Directors—The Board of Governors reviewed the nominations for the Blue Shield Board of Directors, presented by the Blue Shield Nominating Committee, and from the nominations for each physician directorship the following were chosen:

Medical District "A"

Three Year Term

Leo M. Wachtel, M.D., Jacksonville
Fred A. Butler, M.D., Tallahassee

Medical District "B"

Three Year Term

William J. Dean, M.D., St. Petersburg
Irving E. Hall Jr., M.D., Bradenton

Medical District "C"

Three Year Term

W. Dotson Wells, M.D., Fort Lauderdale
Myrl Spivey, M.D., West Palm Beach

At Large

Three Year Term

Edward L. Cole Jr., M.D., St. Petersburg
James M. Ingram Jr., M.D., Tampa

The two lay members nominated by the Nominating Committee were approved by the Board as follows:

Medical District "A"

Three Year Term

Ben C. Willis, Tallahassee

Medical District "B"

Three Year Term

William M. Hollis, Lakeland

Board Actions of Importance

Florida Professional Council—Approved the Association's participation in the Florida Professional Council composed of representatives of six professions—law, medicine, dentistry, architecture, engineering and certified public accounting.

State Medical Scholarship Program—Recommended to the Florida State Board of Health that the State Medical Scholarship program be phased out and discontinued.

University of Miami School of Medicine—Approved and supported an increase by the Florida Legislature for the subsidy for medical students attending the University of Miami School of Medicine from \$3,500 to \$4,500.

Public Law 89-97—Approved the FMA President's testimony before the Senate Finance Committee supporting the exclusion of payments for physicians' services under the provision of the basic hospital plan for the aged under Social Security.

General Session—The Board requested that the President's guest speaker's address at the General Session dur-

ing the Annual Meeting be designated the "Abel Seymour Baldwin Memorial Lecture."

Blue Shield—The Board of Governors recommended Florida Blue Shield as the carrier of the voluntary supplemental insurance under the provisions of Title XVIII, Part B, of Public Law 89-97.

Prevailing Fee Concept—Approval was given to Blue Shield of Florida to study the development of contracts utilizing the prevailing fee concept in payment for physicians' services.

The Board further reiterated that the prevailing fee questionnaires were for a study on which Blue Shield can base the premium for a contract of this nature; that a report be made back to the Board of Governors where modifications may be made by both the Board and the House of Delegates whose approval must be given before this program can be instituted.

Workmen's Compensation—Florida Industrial Commission was requested to use the following formula for the division of professional and technical fees for services of radiologists and pathologists and that this division of fees serve until such time as the FMA Relative Value Studies have been revised to include division of these services: Clinical Pathology—professional service 35%, technical 65%; Anatomical Pathology—professional service 80%; technical 20%; Diagnostic Radiology—professional service 40%, technical 60%.

Your Board further agreed that as of May 1, 1966 the Florida Medical Association will only approve and endorse to its membership a Workmen's Compensation fee schedule with a conversion factor of 5.0 "across the board" based upon the 1962 Florida Relative Value Studies.

Federal Funds—Your Board unanimously agreed that the Florida Medical Association will not accept Federal funds for any programs, but only funds from individuals and organizations.

Medical Assistance for the Needy—The Board recommended that the insurance carrier for the supplemental insurance should be the carrier and fiscal agent for state hospital medical assistance for other needy sick and authorized the FMA Task Force to explore with state officials possible methods of accomplishing such objections subject to approval of the Board and the House of Delegates.

Economic Opportunity Act—The Board recommended that county medical societies should have their own program of minimum medical standards and medical supervision in consultation with county health departments, and that the Committee on Child Health be requested to establish criteria for the medical portion of the Head Start Program as guidelines for county medical societies.

Independent Laboratories—The Board requested the Florida State Board of Health to form an Advisory Committee on Independent Laboratories.

AMA Board of Trustees—The Board approved the recommendation of our AMA delegates to nominate Dr. Homer L. Pearson Jr. for reelection to the AMA Board of Trustees.

Heart Disease, Cancer and Stroke—The Board approved the Association's participation in the Florida Advisory Council on Heart Disease, Cancer and Stroke. This Council is composed of four representatives of the Florida Medical Association, a representative from the University of Florida College of Medicine, the University of Miami School of Medicine, the University of South Florida, the Florida Hospital Association, the Florida Heart Association, the Florida Chapter, American Cancer Society, the State Health Officer and two members of the Board of Regents.

Postgraduate Education—Approved in principle co-operating with the University of Florida College of Medicine and University of Miami School of Medicine in a postgraduate medical education program on educational television.

ODMC—Agreed that at the expiration of the current contract with the Office for Military Dependents' Medical Care future Association approval will be based upon the

acceptance of a conversion factor of 5.0 "across the board" based on the 1962 Relative Value Studies with revision and the contract not be renewed unless this requirement is met.

Vocational Rehabilitation—The Board accepted and acknowledges with appreciation the Division of Vocational Rehabilitation's action in approving the Association's recommendation to adopt a conversion factor of 5.0.

Medicare—The Board requested that the Blue Shield Board of Directors be requested not to enter into any contract with the federal government for Title XVIII, Part B, if it is other than as insurance carrier without consulting the Board of Governors of the Florida Medical Association.

Recommendations

BY-LAWS.—After careful consideration, the Board of Governors recommends to the House of Delegates the following amendments to the current By-Laws of the Florida Medical Association, Inc.:

1. Chapter IX, Section 1, paragraph 1 be amended to read as follows:

"THE COUNCIL ON ALLIED PROFESSIONS AND VOCATIONS: Committees on Dentistry, Law, Medical Assistants, Medical Technologists, Nursing, Pharmacy, Physical Therapy, Religion, Veterinary Medicine and RADIOLOGIC AND NUCLEAR MEDICINE TECHNOLOGISTS."

(This changes the name of Committee on X-Ray Technicians.)

2. Chapter IX, Section 1, paragraph 5 be amended to read as follows: "THE COUNCIL ON MEDICAL ECONOMICS: Committees on Blue Shield, Health Insurance, Fee Schedules, Occupational Health, MILITARY DEPENDENTS' MEDICAL CARE and Members' Insurance.

3. Chapter IX, Section 2, sub-section 5 be amended to read:

"5. MILITARY DEPENDENTS' MEDICAL CARE.—This Committee shall be composed of a minimum of six members selected by the President to include representatives of the medical practice fields of Obstetrics and Gynecology, General Surgery, General Practice, Internal Medicine, Pediatrics, and Radiology. The Committee may be increased by direction of the Board of Governors or upon request by the Chairman. The members shall be selected as equitably as possible from the four Medical Districts, and their terms of four years shall be staggered to provide for a minimum change of members in any one year.

(This changes the name of the Medicare Committee to Military Dependents' Medical Care Committee.)

Subcommittees of the Board

Inter-American Relations—The Subcommittee on Inter-American Relations met on April 22, August 9, September 19, December 5, 1965, and February 6, 1966.

The most important action of the Subcommittee was the formation of the Florida Medical Inter-American Foundation, Inc., which was incorporated May 31, 1965, with the following officers and members as directors: John J. Fisher, M.D., President; Leo M. Wachtel, M.D., Vice President; Floyd K. Hurt, M.D., Secretary-Treasurer; Richard P. Schmidt, M.D., William P. Clarke, M.D., Jacob R. Rozier, M.D., David A. Ohlweiler, M.D., N. Worth Gable, M.D., and Wilson T. Sowder, M.D.

The main activities were devoted to the establishment and maintenance of the Hospital Salvador Paredes, Trujillo, Honduras, C. A. This hospital was dedicated on July 4, 1965, with the Florida Medical Association being represented by George S. Palmer, M.D., President-Elect; Emmet F. Ferguson, M.D., William P. Clarke, M.D., W. David Coyner, Executive Assistant; and the Chairman of the Subcommittee.

Physicians who have served at this hospital include Marian A. Floyd, M.D., Walter W. Sackett Jr., M.D., Henry M. Stern, M.D., William P. Clarke, M.D., and the Chairman of the Subcommittee, James J. DeVito, M.D., is planning to serve between the time of the submission of this report and the annual meeting. The hospital is in

operation, with major surgery and patient care being performed.

The largest problem is obtaining equipment and supplies and trained personnel. Full time Honduran physicians and a Medical Director have been obtained to carry on the work during the intervals between Florida physicians.

An exhibit on the project will be presented at the annual meeting of the Association. The exhibit is designed to increase the interest of individuals within the Association.

Quackery—The Subcommittee on Quackery has had liaison with the AMA Committee on Quackery. The chairman has collected pertinent information and material.

It is recommended that the new committee continue to compile this information in readiness for positive action when the government, State Board of Health or Board of Governor deems the time opportune.

Venomous Snake Bite—The Subcommittee has continued with the cooperation of the physicians of Florida to accumulate data on venomous snake bites. Mr. George Gehres, Accident Prevention Consultant of the Florida State Board of Health, has continued to analyze these data.

The main problem that has developed in the past year has been a decrease in the availability of coral snake antivenin. A letter making suggestions for development of this antivenin and making it more available was sent to the Board of Governors at Mr. Gehres' suggestion. Since this has been sent, it has been found that there were eight reported cases of coral snake bites in 1965. Currently, there have been more vials made available from the Instituto Butanan in South America. It is my understanding that the Food and Drug Administration has not approved the general purchase of this antivenin and there is a problem of our developing it domestically. Dr. Joseph Gennaro, of the University of Louisville, has developed an antivenin for the coral snake that can be used intravenously and is currently quite effective.

The problem of basic research in how this venom affects the various body organs, not only for the coral snake but for all poisonous snakes, needs to be carried out. It is felt this is necessary because of the possible development of anaphylactic reactions in persons who have had one course of treatment and are bitten the second time.

The Committee has functioned in complicated cases by asking questions that are intended to be informative and of an educational nature rather than to criticize any treatment performed.

Dr. Annis: "In the report of the Judicial Council, recommendation No. 1 and Resolution 66-21 on Corporate Practice were considered together. The Reference Committee heartily endorses the resolution that the Florida Medical Association give all possible support to the radiologists, pathologists and other hospital-based physicians in our Association and, with the Judicial Council, regrets the slow progress that is being made by county medical societies in implementing the policy of this House of Delegates, the American College of Radiology and the College of American Pathologists in establishing separate professional fees for these specialties within the state of Florida. Endorsement of this policy was given to the Reference Committee by representatives of the Florida Society of Pathologists and the Florida Radiological Society. No objection to this policy was voiced.

"This Reference Committee recommends approval of recommendation No. 1 of the Judicial Council and of resolution 66-21, Corporate Practice, as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Dr. Annis: "Recommendation No. 2 is approved by the Reference Committee and was considered in conjunction with resolution 66-17, Osteopathy; resolution 66-18, Osteopathy, and resolution 66-19, Osteopathy—Fisherman's Hospital.

"The Reference Committee believes that the basic policy of this Association regarding osteopathy should not be altered at this time, but that it should be the subject of constant review by this House.

"This Committee recommends that a substitute resolution be offered for resolutions 66-17, 66-18 and 66-19."

Dr. Annis read the substitute motion in its entirety.

Dr. Annis: "Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Dr. Annis: "On recommendation No. 3, your Reference Committee heard lengthy testimony on the censure of the emergency room coverage at Broward General Hospital by the Judicial Council and it heartily commends the positive and farseeing action of the Judicial Council in this respect. In addition to endorsing the recommendations of the Council, it would point out to this Association that such emergency room coverage encourages and enhances the hospitals' intrusion into the private practice of medicine through default of independent physicians to discharge their obligations to the patients in their communities. The Committee considers this a fundamental violation of the physician's obligation and believes that if such a tendency is encouraged, it will hasten the demise of the private practice of medicine. We heartily concur in the action of the Judicial Council in this respect.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Dr. Annis: "The Reference Committee recommends approval of recommendation No. 4 assigning Baker County to Nassau County Medical Society for supervision until such time as it may

be organized as a separate component county medical society.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Dr. Annis: "Recommendation No. 5 of the Judicial Council regarding the amendments to the Medical Practice Act were duly considered by your Committee, and it was thought that these recommendations represented the consideration of, rather than solutions to problems in these areas. For this reason, it was concluded that the five points of recommendation No. 5 should be referred to the Board of Governors of the Florida Medical Association for careful study and subsequent report to this House, such study to be made in conjunction with the State Board of Medical Examiners, the officers of component county medical societies, and any other committees or individuals interested or involved in these recommendations.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Dr. Annis: "Recommendation No. 6 involving an additional procedure in the Rules and Procedures of the Judicial Council is amended by the insertion of the word 'apparent' before the word 'illegal' in the second line; by changing the word 'shall' to 'may' in the fourth line; the insertion of the word 'directly' after the word 'referred' in the fourth line; and by changing the word 'will' to 'may' in the fifth line, so that the final procedure will read:

"7. In instances where a component county medical society has discovered evidence of apparent illegal or unethical conduct, or professional incapacity or incompetency, it may be referred directly to the Judicial Council of the Association, who may in turn refer matters to the State Board of Medical Examiners."

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Dr. Annis: "Your Committee considered the Judicial Council actions in rendering specific opinions and endorses these actions."

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Dr. Annis: Your Committee commends the members of the Committee on Archives for their dedicated work during the past year and urges all

members of the Association to cooperate with them in their efforts to obtain complete data on all members of this Association. We congratulate them on the historical issue of The Journal of the Florida Medical Association and we recommend the acceptance of their report as printed in the Handbook and the supplemental report of the Committee on Archives as included in the delegates' packets.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Dr. Annis: "The Committee approves the report of the Grievance Committee as printed in the Handbook."

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Dr. Annis: "The Committee approves the report of the Committee on Medical Licensure as printed in the Handbook."

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Dr. Annis: "Mr. Speaker, I move the adoption of the Report of the Judicial Council as amended."

Motion was seconded and carried.

Judicial Council

JOHN J. CHELEDEN, *Chairman*

Council:

The Judicial Council met on November 14, 1965, and on March 26, 1966.

In compliance with the directive of the House of Delegates, each county medical society was notified of the Association's policy regarding contract medicine and of the previous House policy recommending it be implemented by the local county medical societies in conjunction with the specialty society involved. The Council was advised of the leadership being provided by the Florida Society of Pathologists and Florida Radiological Society and they are to be complimented for their progress.

Recommendation:

1. The Council notes with displeasure the slow progress being made by the county medical societies in implementing the policy of the House of Delegates, and urges very strongly that this implementation be speeded up.

The Judicial Council reviewed a request for an opinion from the Dade County Medical Association regarding Fishermen's Hospital at Marathon, and the policy adopted by the Monroe County Medical Society.

Recommendation:

2. That unusual circumstances surrounding the Fishermen's Hospital in Marathon, Florida, in rendering medical services to the public justifies an exception to the Ruling of the House of Delegates and recommends that a mixed staff be allowed in this hospital.

The Judicial Council reviewed an arrangement for Emergency Room Coverage at Broward General Hospital and requested a review by the Broward County Medical Association.

Recommendation:

3. That the arrangement for Emergency Room Coverage at Broward General Hospital is in violation of the policies of the Association regarding contract medicine in the following three areas: (1) salary should not be guaranteed; (2) the billing must be in the name of the individual physician who renders the service; and (3) the method of division of fees among the physicians involved is unsatisfactory.

The Council reviewed a report from a county medical society insurance committee dealing with overutilization by one of its members, and referred it to the Committee on Membership and Discipline for investigation and report.

A complaint regarding physicians services received from the Florida Industrial Commission was referred to the appropriate county medical society, which investigated and found the complaint was unfounded.

Recommendation:

4. In compliance with the By-Laws, the Judicial Council recommends that Baker County be assigned to the Nassau County Medical Society for supervision until such time as it can be organized as a separate component county medical society.

The Judicial Council reviewed prospectus of the Universal Medical Services, Inc., of Cocoa, Florida, which is a corporation which purveys physicians services. This matter was referred to the Florida State Board of Medical Examiners and to the Association's legal counsel for review to ascertain if it violates the corporate practice of medicine act and, if so, for referral to the appropriate state agency.

The Council reviewed correspondence from the American Medical Association concerning physician ownership of drug repackaging firms. The Judicial Council was of the opinion that this matter be held in abeyance until there is a specific complaint against a specific member with definitive information regarding a violation of the principles of medical ethics.

The Council reviewed the correspondence in which opinion 64-8 was rendered and referred back to the Council by the House of Delegates for clarification. Upon reconsideration, the Judicial Council was of the opinion that the intentions were clearly stated as reported in 1965, and opinion 64-8 should stand as stated. The Council will be happy to discuss the details of this opinion with any member of the Association requesting it.

The Judicial Council reviewed specific grievances at the request of the Chairman of the Grievance Committee.

Recommendations:

(5. The Judicial Council recommends the following amendments to the Medical Practice Act to be referred to the legislative council for implementation at the appropriate session of the Florida Legislature:

1. Limited reciprocity by endorsement, including basic science.
2. Incapacity and incompetence.
3. Injunctive powers.
4. Enforcement of medical practice act to stop unauthorized practice of medicine.
5. Evidence of continued education by licensees.*

6. The Council recommends an additional procedure to be added to the Rules and Procedures of the Judicial Council:

"7. In instances where a component county medical society has discovered evidence of apparent illegal or unethical conduct, or professional incapacity or incompetency, it may be referred directly to the Judicial Council of the Association,

which may in turn refer such matters to the State Board of Medical Examiners."

In response to requests for opinions from the Judicial Council, the following opinions were rendered after consideration by the Council:

65-1: Sharing Office with Optometrist.—There is no objection to a physician renting an optometrist office space; however, the physician's practice should be kept distinctly separate, and he should not share waiting room space or entrances; the Judicial Council also concurs in the Opinions of the AMA in this matter, as recorded on pages 13 and 14 of the Opinions and Reports of the Judicial Council.

65-2: Mail Solicitation by Medical Laboratories.—In the matter of mail solicitation by medical laboratories, the advertising is acceptable because the advertising material is directed from doctor to doctor, and does not go to patients or to the public; however, no schedule of fees may be included in such advertising material.

65-3: Weight Reducing Institution.—The Council is not in favor of the type of weight reduction methods used by the institution in question (where patients are instructed to have their blood pressure and weight checked weekly or every few weeks by their own doctor) without supervision of a medical doctor; however, it sees nothing unethical in a physician giving the patient his weight and blood pressure at the patient's request. It was also decided that the doctor should be reminded that he has the privilege of refusing these patients, if he wishes.

65-4: Physician Ownership of Nursing Homes.—There is no breach of ethics involved in physician ownership of nursing homes.

65-5: Cooperation with a Chiropractor in Court Case.—A physician can work with the lawyer and the court in such a case, provided he does not confer or consult with the chiropractor who had also treated the patient.

65-6: Evaluation of Pharmaceutical Corporations.—The Council is not in a position to evaluate pharmaceutical corporations, and whereby the Florida Medical Association is not qualified to evaluate them, the Council does not feel that the county medical society is qualified to do so either.

Committees:

Committee on Archives—The Committee on Archives for the year 1965-1966 has transacted its business by a newsletter in June of 1965, a telephone conference on October 2, 1965, and a telephone conference in March 1966.

We have continued our campaign to obtain complete Archives Data Forms from all members of the Florida Medical Association by contacting the editors of all medical society bulletins and all of the county secretaries, urging them to publicize our campaign. We have also sent each secretary a list of the doctors who have not returned their forms and urged the secretary to contact these doctors. Despite a strenuous effort the results have not been very gratifying.

We have continued to push the project to assemble data for a history of medicine in Florida. To this end, we have scanned and catalogued more than 150 books, journals, pamphlets, newspaper items, and manuscripts containing material of value.

During the FMA convention of April 1965, we conducted a brief memoriam for the deceased members of our society and we arranged for individual portraits of all members who joined our association prior to 1927. At registration we gave them a distinctive ribbon to identify them. We also had a well-attended reception for these members at which time a group picture was taken and subsequently published in the FMA Journal. We are

*Not approved—referred to Board of Governors for study and report.

planning similar activities for the meeting of May 1966.

With the enthusiastic cooperation of Dr. Thad Moseley, the Editor of The Journal of the Florida Medical Association, we sponsored a historical issue of that journal in July of 1965. This was well received. We are in the process of obtaining material for a similar issue for July 1966.

The Association has lost a number of its fine members during the past year and a list of these names will be included in the Delegates' packets.

Recommendations:

The Committee on Archives would like to submit the following resolution for the action of the House of Delegates:

Whereas, ABEL SEYMOUR BALDWIN was a vigorous, enthusiastic, brilliant, and unselfish citizen of Florida and promoter of our state's welfare, and

Whereas, ABEL SEYMOUR BALDWIN was equally outstanding in promoting the advancement of the profession in the practice of medicine within the state and the chief organizer and first President of the Florida Medical Association, be it therefore

RESOLVED, That henceforth the President's Guest Lecture be designated as the "Abel Seymour Baldwin Memorial Lecture."

**Supplemental Report
COMMITTEE ON ARCHIVES**

The Association has lost a number of its fine members during the past year and a list of these names is given below.

January 1964

Marvin L. Cullen—Hillsborough

March 1964

Luther S. Luppold—Dade

May 1964

William J. McKnight—Pinellas

November 1964

William W. Davies Jr.—Dade
Edward W. Ford—Putnam
Reden R. Williams Sr.—Hillsborough

February 1965

Emmett E. Martin—Polk

March 1965

John W. Chenault—Sarasota
F. E. Kitchens—Dade
Abraham Lustgarten—Dade

April 1965

E. Gordon Aldrich—Sarasota
Ben L. Fabric—Dade
William H. Garlington—Orange
Leander J. Graves—Leon-Wakulla-Jefferson
John C. O'Dell Jr.—Manatee
Ludo von Meysenbug—Brevard

May 1965

Keith D. Banks—Broward
Roderic L. Boling—Pinellas
J. Kenneth Cole—Dade
Isaac M. Hay—Brevard
Arthur R. Knauf—Hillsborough
Wallace E. Winter—Marion

June 1965

Thomas S. Adams—Duval
Donald D. Carter—Pinellas
Fred S. Gachet—Polk
Bruce M. Hogg—Dade
Joseph W. White—Broward
Harry E. Wolk—Dade

July 1965

Chester M. Askue—Charlotte

Stanley Erwin—Duval
Kermit H. Gates—Dade
Samuel Kaplan—Dade
Bernard S. Kleinman—Dade

August 1965

Edgar Austin—Hillsborough
Anthony J. Barranco—Polk
George E. Cram—Palm Beach
Candler K. Hayes—Dade
Lockland V. Tyler—Duval

September 1965

Emil M. Isberg—Dade
Taylor Lewis—Dade
Robert Y. H. Thomas—Duval

October 1965

B. Bowman Guerin—Indian River
Harold H. Ring—Madison
T. Hugh Roberts—Polk

November 1965

Herschel G. Cole—Hillsborough
Robert L. Crews—Dade

December 1965

Virgil M. Bradshaw—Hillsborough
Stephen L. Kyler—Palm Beach
Herman Moss—Duval
Walter T. Hotchkiss—Dade

January 1966

John B. Brinson Sr.—Leon-Wakulla-Jefferson
Roddy A. Field III—Orange
Willard A. Van Nest—Volusia

February 1966

M. Eldridge Black—Pinellas
John A. Ritchie—Duval
Hyman Sporn—Broward

March 1966

Peter Gaetano—Dade
Henry O. Heath—Escambia
Raymond Howe—Volusia
Morris J. Levine—Dade
Harry M. Merchant—Alachua
Paul S. Roland—Dade
John W. Shisler—Dade
James F. Sistrunk—Broward

April 1966

Herbert A. Leavitt—Dade

May 1966

Falkiewicz, Rafal A.—Pinellas

Grievance Committee—Twenty-one grievance complaints against members of the Florida Medical Association have been considered by this Committee during the year. Quite voluminous files developed from the investigations of two or three. Twenty of the complaints were referred to the county society grievance committees for review and recommendation. On only a few have the county society committees not yet reported. All other complaints have been resolved and in only three cases was further assistance from this Committee necessary to accomplish resolution. In general, complaints have been excellently handled by the local county societies.

Recommendations:

This Committee commends the county grievance committees involved for their fine cooperation and successful work.

We wish to suggest that county committees that have determined to make a recommendation to or to reprimand a physician member should not send exact copies of such correspondence with the physician to the party making the complaint.

Committee on Medical Licensure—As usual, we have had a very active year. We have had five full Board

meetings and four hearings heard before one or more members of the Board appointed as hearing officers.

We have revoked four licenses, as follows:

Albert Reinherz—ambulance chasing

Francis A. Brunson—advertising the cure of asthma (alergimist)

Joseph ReKant—unprofessional conduct, as continuing prescribing narcotics for known addicts after several warnings.

Jesus C. Randolph—conviction of abortion

We have enforced suspensions in three instances:

Kent P. Bradley—addiction

Joseph H. Deatsch—addiction

James J. Goodman—voluntary suspension pending request for compromise and settlement, which was denied, mental incompetency.

We have on probation seven; reprimanded, seven; probation continued from 1964, nine.

The Board examined 526 applicants for licensure, and issued 510 licenses.

Resolution 66-21

Corporate Practice Board of Governors

Whereas, It is the policy of the American College of Radiology that the members of the College shall separate their professional fees from hospital charges and present their own bills to all patients expected to pay for certain services, and

Whereas, Because the Congress established in the Medicare Law, P. L. 89-97, provisions covering radiology solely as a Medicare service and in response to the College's urgent request and that of the American Medical Association, radiologists have an obligation to make that portion of the program work as written, and

Whereas, The Attorney General of the State of Florida has ruled that a corporation cannot practice medicine in the State of Florida, and

Whereas, The Judicial Council of the Florida Medical Association reported to the Board of Governors on July 15, 1964 that it unanimously agreed "to reaffirm the ethic that a physician should render the bill to the patient for his services and his services alone:" now, therefore be it

RESOLVED, That the Florida Medical Association give all support to the radiologists of this Association so that the above goals may be obtained.

Substitute Resolution 66-17

(Also for 66-18 & 19)

Osteopathy

RESOLVED, That this House of Delegates re-affirm its position on osteopathy taken in 1963 emphasizing the distinct division between the cult of osteopathy and the profession of medicine, and

RESOLVED, That under ordinary circumstances no cooperation or consultation be undertaken between the medical profession and the cult of osteopathy, and

RESOLVED, That it is recognized that extenuating circumstances exist in several portions of the state, making such limited cooperation and consultation necessary in the best interest of the patient, and

RESOLVED, That wherever such instances occur, they be brought to the attention of the Judicial Council for special ruling and dispensation, and be it further

RESOLVED, That the Judicial Council shall be given an increased flexibility in carrying out the policy of this House of Delegates concerning osteopathy in specific instances and in rendering opinions that are in the public interest.

Dr. Annis "The report of the Council on Special Activities is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Council on Special Activities

DUNCAN T. McEWAN, *Chairman*

Council:

This Council has not met during the year, but the individual Committees have carried out their respective responsibilities and activities.

Committees:

Board of Past Presidents—Your Board of Past Presidents meets each year at the time of the annual meeting. Last year, it designated one of its members to serve on the Judicial Council, judged the Scientific Exhibits and conducted other routine business. Individual Past Presidents have assisted the Association when called upon during the year.

Advisory to Woman's Auxiliary—The Committee members for 1965-1966 have been: Lee Rogers Jr., M.D., Cocoa, Chairman; Abbott Y. Wilcox Jr., M.D., St. Petersburg; Eugene B. Maxwell, M.D., Tampa; Gordon H. Ira, M.D., Jacksonville; and Donald F. Marion, M.D., Miami.

Throughout the past year the chairman of the Committee has been in touch with the President of the Woman's Auxiliary to the Florida Medical Association, Mrs. H. Quillian Jones Sr., and has been ready for the Committee to assist the state auxiliary if called upon. No meeting of this Committee has been necessary this year.

The Committee wishes to compliment the Woman's Auxiliary for another very fine year.

AMA House of Delegates—All delegates were in attendance at all four AMA meetings, along with Mr. Parham, our Executive Director. The directives of FMA were carried out. All proceedings of both meetings have been published in J.F.M.A. and J.A.M.A., and the AMA News.

Dr. Annis: "The Committee considered resolution 66-15, History of Medicine Museum, as printed in the Handbook and recommends that this resolution be approved in principle and referred to the Board of Governors for study by appropriate segments of the Florida Medical Association, necessary action, and immediate implementation within this coming year, with the recommendation that the overall program be under the direction of the Committee on Archives of the Judicial Council.

"Mr. Speaker, I move the adoption of this portion of the report."

Resolution 66-15

History of Medicine Museum St. Johns County Medical Society

Whereas, This year of Our Lord nineteen hundred and sixty-five, A.D. is the 400th Anniversary of St. Augustine, Florida, the Nation's Oldest City; and,

Whereas, The restoration of our Nation's Oldest City seems an assured success, we of the St. Johns Medical Society feel that it is appropriate and timely for the Florida Medical Association to establish a museum of the history of medicine in Florida; one of the earliest hospi-

tals in the state of Florida and the Nation has been restored and is available for a project of this nature; therefore be it

RESOLVED, That we request the President of the Florida Medical Association to appoint an appropriate committee to make a study of this project and offer recommendations for action by the entire Association. We ask each County Medical Society to join with us in making this idea a reality.

Dr. Annis: "The remarks of the Speaker were considered by your Committee, which wishes to commend the Speaker for his clear, succinct explanation of the rules of procedure of the House of Delegates and for his admirable and efficient conduct of the meeting of the First House of Delegates.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Dr. Annis: "The annual address of the President of the Florida Medical Association was re-

viewed by your Committee, and is commended to the thoughtful consideration of each member of this body. The surprising brevity and directness of these remarks were appreciated by the members of this House and serve to acknowledge the capable and efficient leadership which we have enjoyed during the past year.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Dr. Annis thanked the many members of the Association who appeared before the Committee and the several members of the Committee for their dedicated efforts.

Dr. Annis: "Mr. Speaker, I move the adoption of this entire report as amended."

Motion was seconded and carried.

The Vice Speaker, Dr. James T. Cook, took the Chair.

Report of Reference Committee No. IV

Legislation and Miscellaneous

Dr. Louis M. Murray: "Mr. Speaker, Mr. President, and Members of the House of Delegates:

"Your Reference Committee gave careful consideration to items referred to it and makes the following report. The Committee's recommendation on each item will be submitted separately and we request that each item be acted upon separately before proceeding to the next.

"The Reference Committee considered the report of the Council on Legislation and Public Agencies and recommends that it be approved as printed in the Handbook and that Dr. Joseph C. Von Thron and his Council be commended for their excellent job.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.



Reference Committee IV membership included Drs. Louis C. Murray, chm., Fred A. Butler, Francis C. Coleman, David W. Goddard and David Kirsh.

Dr. Murray: "Mr. Speaker, the Committee considered the supplemental report of the Committee on National Legislation and recommends that it be approved with the first 14 lines of page two deleted.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded.

Dr. Charles R. Sias, of Orange: "I move to amend the report to add that the policies approved in this supplemental report be transmitted to the AMA delegates to be presented to the American Medical Association House of Delegates at its June 1966 meeting with the recommendation that it take similar action."

Amendment was seconded and carried.

Motion was carried.

Council on Legislation and Public Agencies

JOSEPH C. VON THRON, *Chairman*

Council:

During the past year the Council met for the purpose of considering pending items of importance. At the time of the meeting there were no matters requiring immediate action as regards national legislation; however, the following recommendations as developed by the Council and submitted to the Board of Governors were favorably approved.

Recommendations:

- 1) **Key Contact Physicians.**—That in working with and through the county medical societies Key Contact Physicians be designated for each state legislator. The arrangement of Key Contact Physicians has proved valuable over the years in that excellent liaison and rapport has been established with the Florida Congressional Delegation.
- 2) **FLAMPAC.**—That appropriate liaison between FLAMPAC and the Committee on State Legislation be established and that FLAMPAC policy be changed so as to provide that funds solicited from Florida physicians be used for both state and national political educational activities.
- 3) **COMAH.**—By action of the Board of Governors, the Committee on Medicine and Hospitals was dissolved with the purpose in mind that a draft of a plan for a new organization outlining the functions, suggested composition, and financing be reported back to the Board.
- 4) **Third Medical School.**—The Council on Legislation concurs with the previously expressed opinion of the Council on Medical Education and Hospitals that the facilities of the two existing medical schools should be fully utilized prior to the establishment of a third medical school. This matter remains of continuing interest and is to receive further joint consideration by the Council on Medical Education and Hospitals and the Committee on State Legislation.

The state legislative program for the Association during the 1967 session is in process of development and will be reported in the supplemental report for the Committee on State Legislation.

Committees:

National Legislation.—All physicians are aware that passage of the Social Security Amendments of 1965, as

signed into law by President Johnson on July 30, will bring many changes which will directly or indirectly affect the practice of medicine and the future health care of every American. In summary, the new law (P.L. 89-97) adds two new titles to the Social Security Act. In addition to the better known Title XVIII (Parts A. and B.), Health Insurance for the Aged, the law inaugurates Title XIX, Grants to States for Medical Assistance Programs. The AMA has advised that a preliminary estimate indicates that \$29 million will be taken out of Florida by tax contributions for the Hospital Insurance Trust Fund in 1966.

It is of prime concern that all physicians direct their interest toward continued support of the AMA advisory efforts to develop workable and acceptable federal regulations to govern state implementation of the provisions of the Medicare law. Of recent date, our Florida Congressional Delegation was contacted for the purpose of requesting their assistance in seeking to have the Department of HEW comply with the expressed legislative intent and wording of the Medicare statute as written in order that professional services of pathologists would be paid for under Part B. of Title XVIII in lieu of Part A.

Tentative plans are that our Key Contact Physicians will again visit with the Florida Congressional Delegation in Washington.

Subcommittees:

Liaison with Federal Agencies.—The Committee has continued to operate as liaison between members of the Florida Medical Association and the Veterans Administration.

During the entire year we have negotiated with the Veterans Administration in reference to the Veterans Administration Fee Schedule. The current agreement with VA ended approximately one year ago, at which time the committee carried to the VA the action of the Board of Directors that all fees be based on the Florida Medical Relative Value studies with the conversion factor of five. As of this date the VA has not agreed with this recommendation, although a copy of the action of the Board of Governors has been forwarded to it. This information is now being studied in Washington and it is hoped that a long overdue revision of this fee schedule can be brought about promptly.

Liaison with Department of HEW.—The Chairman has kept liaison with the Department of HEW through his membership on the State Welfare Board and through meetings with the Social Security Administration as President-Elect of the American Association of Medical Clinics. In addition, he has been in contact with Mr. Wilbur Cohen on some of the questions concerning implementation of Title XIX. No formal meetings of the Committee have been called.

State Legislation.—The Committee is pleased to report that the Association's legislative program during the 1965 session was successful in that major bills were passed relating to: Indigent Care; Good Samaritan; Scientific Medical Investigative Studies; Privileged Communication Between Patient and Psychiatrist; Voluntary PKU Testing; and Prescribed Drug Program for Public Assistance Recipients. Details of these bills and other legislation supported or opposed by the Association were summarized in a legislative bulletin mailed to all county medical societies.

It is expected that full implementation of the provisions of the new Medicare law (P.L. 89-97) will be of major concern during the coming 1967 session. The Committee's attention will be directed toward continued improvement of existing state-federal tax-financed indigent health care programs. The legislature will be urged to provide adequate state appropriations and authorize use of an insurance carrier as fiscal agent in the implementation of Title XVIII (Parts A. and B.), and Title XIX of Public Law 89-97.

Other current items pending Committee consideration are Resolution 64-4 "Consent for Autopsies" and Resolution 65-13 "Medical Coroner System." Further con-

sideration will also be given to pending items which have previously been considered by the Committee with the resulting action that they be included in the Association's long range program. These items include: Corrective legislation with reference to cultist groups; Labeling of poisonous substances; Creation of a commission on welfare services. Recommendations for specific items to be included in the legislative program for the 1967 session are in process of development and will be included in the Committee's supplemental report.

The following recommendation was favorably approved by the Board of Governors.

State Legislative Activities.—That at least once during each year (preferably at the time of the January Conference of Presidents and Secretaries), the chairman of the county medical societies' legislative committees and/or, if established, key contact physicians, be encouraged to attend a session to discuss the FMA legislative program—"How it works and what is necessary to make it successful at the county medical society level."

Supplemental Report

COMMITTEE ON NATIONAL LEGISLATION

Inasmuch as government has announced that it has assumed, under Public Law 89-97, responsibility for financing the medical care of certain segments of the population, the Committee on National Legislation under the Council on Legislation and Public Agencies of the FMA has adopted certain policies for the information and guidance of its members.

For emphasis, reference is made to Title XVIII—Health Insurance Benefits for the Aged, and Title XIX—Grants to States for Medical Assistance Programs.

It is recommended and urged that every physician follow these policies in the conduct of his individual practice of medicine.

Policies Recommended for Individual Physicians

Once the physician accepts a person as his patient, regardless of what third party might be involved, the physician's primary and sole obligation, his contract and his relationship are with the patient.

Any arrangement between government and a citizen whereby the government agrees to pay for the citizen's medical care does not, directly or indirectly, or by inference, involve the physician in a contract with the government.

The physician will continue, even as before, to provide those persons he accepts as patients the best possible medical care at his command.

The physician is requested and urged to deal directly and only with the patient, both in providing medical care and in billing for just compensation for the medical care provided.

It is recommended, inasmuch as the agreement for financial responsibility is between the patient and the government, that the physician not accept any assignment form.

It is recommended, in accordance with the Principles of Medical Ethics, that each and every member of this Association submit to the patient his own bill and receive on his own behalf, compensation for his professional medical services.

In cases where review or mediation may be requested, it is recommended that the standard mediation or review mechanism of the county medical society be utilized. Further, it is recommended that no special review or mediation committee be appointed solely to handle cases involving Public Law 89-97.

Requirement of Pledges or Statements Objectionable

The Profession finds objectionable and distasteful any regulation or requirement that a physician sign pledges or produce statements that he will abide or has abided by the laws in providing his professional services. Such

requirement or regulation is, of itself, an act of discrimination against the profession, and is degrading.

The propriety of the conduct of members of this Association is determined by the Principles of Medical Ethics, to which all members of this Association willingly and freely pledge themselves.

For emphasis, reference is made specifically to Section 4 of the Principles of Medical Ethics: "Section 4. The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. *Physicians should observe all laws*, uphold the dignity and honor of the profession and accept its *self-imposed* disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession."

Dr. Murray: "The Reference Committee considered the report of the Council on Medical Economics and recommends that it be approved as printed in the Handbook, except for the deletion of item 1 under Council's actions, and item 1 under recommendations.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Dr. Murray: "The Reference Committee considered the supplemental report of the Council on Medical Economics and recommends that it be approved.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion seconded and carried.

Council on Medical Economics

JACK A. MACCRIS, *Chairman*

Council:

The Council met on December 5, 1965, at which time pending items and committee reports were considered. The Committee recommendations as approved by the Council and the Board of Governors are included as part of the annual reports of the Committees. The Council has under consideration the Board of Governors' question with reference to fee schedules and it is expected that the Council's action will be reported in the supplemental report. The recommendation under consideration is:

"That with the exception of existing Blue Shield contracts, the Board of Governors recommend that no fee schedules be recognized or approved by the Florida Medical Association and the individual physician be paid his usual and customary fee for the service performed."

The Council's actions regarding other specific items are as follows:

- 1) Over Utilization.—In discussing "over utilization" the consensus of opinion of the Council was that in keeping with the actions of the Executive Committee, appropriate disciplinary action for such involvements should continue to be a responsibility of the Committee on Membership and Discipline which comes under the Judicial Council. It was further mentioned that in keeping with the original concept and establishment of local insurance review committees such committees' responsibilities should be limited to informational and educational pursuits; fee reviews as to usual and customary fees; and where warranted serve as advisory to other committees where possible disciplinary action should be considered.

- 2) Fee Reviews by County Medical Society Insurance Review Committees.—In discussing the recent actions and recommendations of both the FMA Executive Committee and the Board of Governors regarding clarification as to the procedure to be followed by local insurance review committees in reviewing claims, it was decided that no action should be taken at this time. It was mentioned that responsibility regarding fee reviews should be continued as outlined by the brochure entitled "A Guide for use in the Establishment of an Insurance Review Committee of a County Medical Society."

It is hoped that through better understanding and liaison all county medical societies will eventually recognize the merits of establishing local insurance review committees using the guide posts as developed by the FMA Committee on Health Insurance.

The Board of Governors reminds the Council and the Committee on Health Insurance that some action may be taken to have county societies comply with the instructions of the Association if the matter is taken to the Judicial Council.

- 3) Utilization Committees and Studies.—In discussing utilization committees and utilization studies, it was mentioned that because of the pending regulations for implementation of the Medicare program progress in this area has not materialized.
- 4) Assignment of Benefits.—Information to date and responses from physicians indicates that the matter of assignment of benefits is not a state wide problem of major concern to a great number of physicians and that this matter should be kept in abeyance until such time as it warrants thorough investigation and consideration.
- 5) Medical Economics Course.—The Council was apprised of the recent activities and discussion with the Deans of both medical schools regarding a course of medical economics for 4th year medical students. The Chairman of the Council advised that he is to again meet with both Deans, at which time he will strongly urge that the medical schools institute lectures in the following areas:

- a) Organization of medicine.
- b) Physicians fees, and how they are established.
- c) Prepayment plans and commercial health insurance.
- d) Physician-patient relations and the role of physician in community relations.

- 6) Resolution 65-9 entitled "Insurance" submitted by the Monroe County Medical Society and which was not approved by the House of Delegates but was referred to the Board of Governors for study was discussed. It was the consensus of opinion that this matter should be considered by the Committee on Members Insurance and that the Association's insurance program Administrators should explore the possibility of obtaining the best available policy to include, if possible, provisions for noncancellable clause; coverage for all diseases without exceptions; and coverage for total disability on establishment of diagnosis. Recent action in this regard is included as part of the annual report of the Committee on Members Insurance.

Our program administrators advise that the FMA disability plan currently provides that on the premium due date last following an insured's 70th birthday, he may convert within 30 days to the Senior Income Plan without evidence of insurability provided he is not on claim at the time of the conversion. The Senior Income Plan provides coverage until age 75 and at present four FMA senior members are participants in this plan. With regard to the noncancellable clause, there is no knowledge of any company that will provide an association type policy which incorporates such a clause in its contract. The only companies that provide this type coverage are those

writing accident and health insurance on an independent or individual (non-group association) basis.

Recommendation:

In the absence of information to the contrary, the committee is not aware of any problems concerning the age determination date, indemnification for all diseases (without exception or exclusion which relate to pregnancy, suicide, war, etc.). For this reason, it appears that no action is appropriate as regards Resolution 65-9.

- 8) Resolution 65-14 entitled "Fee Schedules" as approved by the House of Delegates was considered and it was mentioned that the Committee on Fee Schedules and the Council on Specialty Medicine are presently directing activities to comply with the intent and purposes of this resolution.

Committees:

Committee on Advisory to Blue Shield.—The Chairman is pleased to report that the Committee on Advisory to Blue Shield met twice during the year at which time lengthy consideration was given to the following two items of major concern to all members of FMA and Florida Blue Shield.

Prevailing Fees Concept.—At the request and direction of the Board of Governors, the Committee gave thorough consideration to the development of the proposed prevailing fees survey which was mailed to all FMA members. Individual committee members gave of their valuable time in conducting informational programs at the county medical societies' monthly meetings. In discussing the prevailing fees survey with the membership of county medical societies, as well as individual physicians, it was recognized that many physicians were grossly suspicious of the survey for various reasons. The main objections were attributable to the difficulty in providing physicians with detailed information and adequate explanation as to the objectives and intent of the prevailing fees concept. Specific objections expressed were that the prevailing fees program would result in establishment of fixed fees. It is recognized that the Medicare program has also influenced the physicians' attitude toward participation and acceptance of this new concept. The Committee's action in this regard is included in the recommendations below.

Blue Shield-Blue Cross Complementary Coverage.—The Committee considered the proposed Blue Shield-Blue Cross Complementary Coverage contract which had been approved by the Blue Cross Board and the Blue Shield Board. In considering this matter it was called to the attention of the Committee that organized medicine had been instrumental in having deductibles included as part of the Medicare Law as a deterrent to utilization and that this type of coverage would, in effect, negate the purpose of deductibles. The Committee was also apprised that commercial health insurance carriers currently have similar contracts available and are developing additional contracts to further supplement the Medicare program. The Committee was also aware that commercial insurance companies have expressed competitive interest in providing this type of coverage in that both Blue Cross and Blue Shield have been designated carriers for the Medicare program. The Committee's action in this regard is expressed in the following Resolution:

RESOLUTION

Blue Shield Contracts

Whereas, Deductibles are part of the Medicare Law to influence utilization, and,

Whereas, It is presently the physicians' responsibility to control utilization, and,

Whereas, The cost to the patient for services provided in a physician's office should be on a par with cost to the patient in the hospital, and,

(Continued on page 626)

in diarrhea

LOMOTIL[®] Tablets
Liquid

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride 2.5 mg.
(Warning: May be habit forming)
atropine sulfate 0.025 mg.



is a corker

Effectiveness: Lomotil possesses a unique degree of effectiveness in both acute and chronic diarrhea.

Convenience: Lomotil is supplied as small, easily carried, easily swallowed tablets and as a pleasant, fruit-flavored liquid.

Versatility: The therapeutic efficiency, safety and convenience of Lomotil may be used to advantage alone or as adjunctive therapy in diarrhea associated with:

- Ulcerative colitis
- Acute infections
- Irritable bowel
- Regional enteritis
- Drug therapy
- Food Poisoning
- Functional hypermotility
- Malabsorption syndrome
- Ileostomy
- Gastroenteritis and colitis

Dosage: For full therapeutic effect—Rx full therapeutic dosage. The recommended initial daily dosages, given in divided doses, until diarrhea is controlled, are:

Children: 3 to 6 months — 3 mg. (½ tsp.* t.i.d.)
6 to 12 months — 4 mg. (½ tsp. q.i.d.)
1 to 2 years — 5 mg. (½ tsp. 5 times daily)
2 to 5 years — 6 mg. (1 tsp. t.i.d.)
5 to 8 years — 8 mg. (1 tsp. q.i.d.)
8 to 12 years — 10 mg. (1 tsp. 5 times daily)

Adults: 20 mg. (2 tsp. 5 times daily or 2 tablets 4 times daily)

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the therapeutic dose.

Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is a Federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

SEARLE

Research in the Service of Medicine

Whereas, The present complementary Blue Shield-Blue Cross coverage will tend to divert patients to the hospital and thus increase utilization and hospital costs to the detriment of all, therefore, be it

RESOLVED, That the Committee on Advisory to Blue Shield recommends to the Blue Shield Board that no contract, either this one or any other one, be written that is detrimental to the best interest of physicians as opposed to the interest of hospitals; and that the Blue Shield Board be informed of the desires of this committee that no contract be written without having gone through the discussion of this committee.

Indoklon Therapy.—The Committee also considered the request of the Florida Psychiatric Society that Indoklon therapy be paid for by Blue Cross-Blue Shield and that it be recommended for inclusion in other health insurance contracts.

Blue Shield Payment Problem for Psychiatric Services.—Another item of concern was that of the Blue Shield payment problem for psychiatric services provided in the Pensacola area. The Committee's action regarding these two items is included in the recommendations.

Recommendations:

- 1) **Resolution entitled "Blue Shield Contracts."**—That it be recommended that the resolution entitled "Blue Shield Contracts" be approved and implemented accordingly.
- 2) **Indoklon Therapy.**—That it be recommended that Indoklon therapy be paid for on the same basis as other convulsive shock therapy.
- 3) **Blue Shield Payment Problem for Psychiatric Services.**—That it be recommended that the Blue Shield payment problem as regards the concerned physician be referred back to the Insurance Review Committee of the Escambia County Medical Society with the request and suggestion that it be referred to the appropriate hospital utilization committee for review and further recommendations.

Committee on Fee Schedules.—The Committee on Fee Schedules met during the year at which time the following recommendations were developed and were approved by the Board of Governors:

Recommendations:

- 1) **Revision of 1962 FMA Relative Value Studies.**
 - a) To direct each and every specialty group through the Council on Specialty Medicine to re-evaluate the Relative Value Studies in regard to their particular specialty and to inform the Fee Schedules Committee as soon as possible of any considered changes, corrections or additions they wish to make; to ask radiology and pathology to revise their schedules to include two values—the total value and the professional component for the professional services rendered, which will be a fraction of the total fee for that specific item.
 - b) To accept (the list of additions and corrections to the 1962 Florida Relative Value Studies as approved by the Board of Governors on recommendation of the Committee on Fee Schedules in consultation with the Council on Specialty Medicine) for inclusion in the 1962 Florida Relative Value Studies and for inclusion in the subsequent revisions.
- 2) **Alternate Blue Shield "J" Contract**
 - a) To approve the Alternate Blue Shield "J" Contract.
- 3) **Florida Industrial Commission—Workmen's Compensation Program.**
 - a) That an "across the board" conversion factor of 5.0 be instituted as soon as possible.
 - b) **Reduction of Fees.**

To request that the wording "Total fee is broken down only when necessary" be changed to "Total fee is broken down when requested."
 - c) **Emergency Room Fee.**

To make no change in the schedule for emergency room fees but to leave them "By Report."

d) Initial Office Visit.

To refer this subject to the Council on Specialty Medicine for consideration and recommendation.

e) Fee for Sterile Tray.

That the physician is expected to include in his surgical fee all expendable and non-expendable items which are usually used in the procedure; any items beyond the usual may be itemized for compensation and that the Council on Specialty Medicine be advised of this action.

f) Asterisk Procedures.

To leave the matter as it is and express support of the screening procedures currently being used by the Workmen's Compensation Division.

g) Consultations and Evaluations.

To recommend that consultation code numbers 9026, 9027, 9028, and 9029 be made A & A.

The state and federal agencies administering the programs for Workmen's Compensation, Vocational Rehabilitation, Veterans Administration Hometown Care Program, and Medicare (Medical Care for Military Dependents), have been advised of the Association's recommendation that contractual agreements as regards fee schedules which are based on the Relative Value Studies are to be with a conversion factor of 5.0 "across the board" for all services. To date, there have been no notices of acceptance of the recommendation by the agencies concerned.

In carrying out the intent of recommendation 1 (a and b), the Committee is in process of reviewing proposed revisions to the 1962 FMA Relative Value Studies as submitted by the various specialty groups.

Committee on Medicare Mediation.—The statistics in this report are on a calendar year basis to coincide with the accounting procedures of the fiscal administrator, Blue Shield.

During the year, three meetings were held, one in Orlando, one in Miami Beach, and one in Gainesville. Attendance at all meetings was excellent.

Blue Shield paid 15,048 claims to physicians for a total of \$1,359,452.40, a slight increase over 1964 in both claims and payment. The most significant change in Medicare procedure during the year was the work of the Medical Consultant, who reviewed 1,418 claims, greatly relieving the work of the Committee which reviewed only 725 claims. This also enabled the Committee to reduce its meetings from five or six to three.

The county medical society Medicare committees, as always, contributed their valuable assistance in conducting local reviews and making equitable recommendations.

Recommendations:

- 1) That routine Papanicolaou tests in maternity cases be compensable.
- 2) That the proposed revision of the Medicare contract, which deletes some 550 seldom used procedures, adds 4 new codes, adds an asterisk (*) to 7 procedures, and removes the word "initial" from 12 procedures, be referred to the Fee Schedules Committee without recommendation.
- 3) That a minimum fee of \$750 be established for open heart surgery, or that all open heart surgery be on a "by report" basis.
- 4) That a code and relative value be established for amniocentesis in the same category with exchange transfusions with a fee of \$25.00.

Committee on Members Insurance.—The Committee did not meet during the year, however, the Chairman and several officers of the Association met with the Association's insurance program administrators and representatives of the insurance carrier for the professional liability insurance program. The purpose of the meeting was to review the overall activities and the problem areas of the professional liability program. At this meeting, it was pointed out that insurance companies are losing interest in writing this type insurance in Florida and for this reason it is more urgent than ever that FMA have a liability insurance program for its members.

The Committee is pleased to report that the insurers for our plan have been very cooperative in providing reduced coverage for select individuals who have experienced past claim incidents. With the hope that participation will continue to increase, it is expected that the company will become less restrictive and more understanding in its underwriting practices. Until such time as adequate participation is reached, the carrier will continue to exercise individual underwriting with the result that poor risk physicians will not be insured at standard rates. Physicians who have had adverse claim experience will find it difficult or practically impossible to secure this type of insurance at any price. Our continued interest will be to encourage all members to participate in order that the advantages of group buying power may be achieved. It is important that it be made known that each declination or cancellation is thoroughly reviewed by the FMA Executive Committee and the Committee on Members Insurance with the carrier being advised accordingly.

Financial and statistical reports for the membership benefit programs were reviewed and made available to the committee members and the officers of the Association. Due to favorable program experience, the following proposed changes as recommended by Marsh and McLennan, Inc., who serves as the Association's insurance administrators, were favorably approved by the Board of Governors and are now in effect.

- I. Disability Income Protection Plan.
 - a) Present over-all benefits are to be increased 10% for the lifetime accident/short term sickness program.
 - b) The present maximum of \$75.00 weekly for female physicians is increased to \$125.00 weekly for the lifetime accident/two-year sickness plan.
 - c) Provision for inclusion of coverage for private flying at an annual premium of \$6.50 for each \$25.00 weekly indemnity; for each \$1,000.00 of accidental death and dismemberment coverage.
- II. Office Overhead Expense Plan.
The present \$1,000.00 monthly coverage is increased to \$1,300.00 maximum with benefits beginning on either the 16th or 31st day of total disability with the selected total aggregate benefit payable over a three-year term. It is expected that future coverage will be increased to \$1,500.00 maximum.

Supplemental Report COUNCIL ON MEDICAL ECONOMICS

Your Council considered the following motion, which was referred to it by the Board of Governors:

"That with the exception of existing Blue Shield contracts, no fee schedules be recognized or approved by the Florida Medical Association and the individual physician be paid his usual and customary fee for the service performed."

Your Council approves the principle of this motion and recommends its adoption by the House of Delegates.

Dr. Murray: "The Committee considered resolution 66-1, Pathologists—Charges for Services, and recommends that it be approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Resolution 66-1

Pathologists — Charges for Services Dade County Medical Association

Whereas, Pathology has been repeatedly defined as an integral part of the practice of medicine, and

Whereas, The House of Delegates of the AMA, at its October 1, 1965, meeting, has adopted the following statement of policy:

" 'Hospital based' medical specialists are engaged in the practice of medicine. The fees for the services of such specialist should not be merged with hospital charges. The charges for the services of such specialists should be established, billed and collected by the medical specialist in the same manner as are the fees of other physicians," and

Whereas, The College of American Pathologists, the Florida Medical Association, the Florida Society of Pathologists and the Southeastern Florida Society of Pathologists have reaffirmed this principle, and

Whereas, The FMA House of Delegates has, in April 1965, recommended that this policy should be carried out by the local county medical society in conjunction with the specialty involved, now therefore be it

RESOLVED, That the Dade County Medical Association approve the principle of pathologists presenting their own bills to all except indigent patients.

Dr. Murray: "The Committee considered resolution 66-2 and 66-7, Radiologists—Charges for Services, and recommends that they be approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Resolution 66-2

Radiologists — Charges for Services Dade County Medical Association

Whereas, Separate billing by radiologists for professional services was approved by a statement adopted on October 1, 1965, by the House of Delegates of the AMA, and

Whereas, The House of Delegates of the FMA in April 1965, by resolution, reaffirmed the principle that a physician should render a bill to the patient for his services, and that this policy should be carried out by the local county medical society in conjunction with the specialty society involved, and

Whereas, The American College of Radiology has adopted similar policy statements, and the Florida Radiological Society and the Greater Miami Radiological Society have approved these statements, and have asked their members to proceed promptly to arrange separation of their professional fees from hospital services charges, and

Whereas, The specialty of radiology should be recognized as a medical service regardless of the site or circumstances of its performance, now therefore be it

RESOLVED, That the DCMA approve the separation of professional fees and hospital charges for radiologists and urge prompt implementation of this program, and further that a copy of this resolution should be forwarded to the FMA for approval by its House of Delegates at its annual meeting in 1966.

Resolution 66-7

Separation of Professional Fees and Hospital Charges for Radiologists Broward County Medical Association

Whereas, Separate billings by radiologists for professional services was approved by a statement adopted on 1 October by the House of Delegates of the AMA, and

Whereas, The House of Delegates of the FMA in April 1965 reaffirmed the principle that a physician should render a bill to the patient for his services, and that this

policy should be carried out by the local county medical society in conjunction with the specialty society involved, and

Whereas, The American College of Radiologists has adopted similar policy statements, and the Florida Radiological Society has approved these statements, and has asked their members to proceed promptly to arrange separation of their professional fees from hospital service charges, and

Whereas, The specialty of radiology should be recognized as a medical service regardless of the site or circumstances of its performance; now therefore let it be

RESOLVED, That the BCMA approves the separation of professional fees and hospital charges for radiologists and urges prompt implementation of this program; and further, that a copy of this resolution be forwarded to the FMA for approval by its House of Delegates at its annual meeting in 1966.

Dr. Murray: "The Committee considered resolution 66-3, Opposition to Hart Bill, and in accordance with the policy previously adopted by the American Medical Association regarding the Hart Bill, recommends that it be approved.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Resolution 66-3

Opposition to Hart Bill Dade County Medical Association

Whereas, S.2568, The Hart Bill, purports to correct abuses in the practice of medicine and the anti-trust laws, and

Whereas, It actually contains restrictions which would defeat this purpose and which are not in the interest of providing the best medical care for the patient; therefore, be it

RESOLVED, That the Dade County Medical Association go on record as opposing the Hart Bill (S.2568) and that it so inform its representatives in the Senate and House of Representatives, and be it further

RESOLVED, That this resolution be transmitted to the House of Delegates of the Florida Medical Association for approval and submission to the House of Delegates of the American Medical Association.

Dr. Murray: "Serious consideration was given to resolutions 66-4, 66-6, 66-10, 66-12, 66-13 and 66-14. These resolutions are similar in both intent and content and are therefore being replaced by a substitute resolution."

Dr. Murray read the substitute resolution in its entirety.

"Dr. Murray: "Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded.

Dr. Frederick C. Andrews, of Lake: "In the first 'resolved' of this resolution, it says 'strongly favoring the principle of payment to physicians by all government agencies, etc.' and I would like to amend this to read, 'strongly favoring the principle that when circumstances dictate payment of physicians, etc.'"

The amendment was seconded and carried.

Motion to approve the amended substitute resolution was carried.

Substitute Resolution 66-4

(Also for 66-6-10-12-13 & 14)

Whereas, Remuneration to physicians for care of patients under PL 569 (popularly known as Medicare for dependents of Armed Forces personnel) is generally inadequate, and has remained inadequate for many years; and

Whereas, Most medical fee schedules supported by State and County agencies throughout the United States are considerably below the usual and customary fees prevailing in the same areas; and

Whereas, Services other than medical care rendered by individuals to County, State or Federal Governments or their agencies are usually reimbursed at the prevailing salary or fee for such services in that area; and

Whereas, Increasing government support and control of medical services and medical fees is evident and expected, not only for patients with low income, but for those with moderate and high incomes; therefore be it

RESOLVED, That the House of Delegates of the Florida Medical Association go on record as strongly favoring the principle that when circumstances dictate payment to physicians by all government agencies and by government-sponsored or government-guided plans at all governmental levels, of the usual and customary fees prevailing in their area; and further be it

RESOLVED, That this statement be forwarded to the Board of Governors of FMA for appropriate consideration and action.

Dr. Murray: "Resolution 66-5, Support of Blue Shield, was considered by the Committee and we recommend it be approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Resolution 66-5

Support of Blue Shield Orange County Medical Society

Whereas, The Orange County Medical Society believes that Blue Shield of Florida has the ability to provide the best type of pre-paid medical care protection for the citizens of Florida;

Whereas, It is essential that doctors retain control of the practice of medicine, and not lose it to the government, or any other non-medical party; therefore be it

RESOLVED, That the Orange County Medical Society recommends to the Florida Medical Association that Blue Shield of Florida be maintained and strengthened in every way possible; and that individual doctors and county medical societies give this Plan their wholehearted cooperation and support; it is further

RESOLVED, That the resolution be submitted to the House of Delegates of the Florida Medical Association meeting for approval in session at Hollywood, May, 1966.

Dr. Murray: "Your Reference Committee considered resolution 66-8 thoroughly. The Committee brought out the fact that this has been thoroughly studied by the American Medical Association. This study indicated that programs for

professional liability insurance for physicians can best be implemented at the state level. For this reason, your Reference Committee recommends that resolution 66-8 not be approved.

"Mr. Speaker, I recommend that resolution 66-8 not be approved."

Motion was seconded and carried.

Dr. Murray: "The Committee considered resolution 66-9, Anti-Quackery Legislation, and recommends that it be referred to the Board of Governors for further study. The Committee commends the Broward County Medical Association for the intent of the resolution, but because of its many ramifications and legal complexities, thinks it best that it be referred to the Board of Governors for its consideration and action.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Resolution 66-9

(Not approved—Referred for Study)

Anti-Quackery Legislation Broward County Medical Association

Whereas, Various persons in the State of Florida represent themselves as possessing medicines, skills, methods, techniques and devices for the effective diagnosis, treatment and cure of disease; which representations are false and misleading, and

Whereas, The citizens of Florida who accept such representations are being deprived of prompt application of treatment which has a scientific base, and which could result in financial loss, reduction of life span, or premature death, it is

RESOLVED, That legislation establishing an agency empowered to investigate, publish findings, and prosecute quacks and medical charlatans is desirable in the State of Florida.

Dr. Murray: "The Committee considered resolution 66-16, Diagnostic Services, and recommends that it be approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Resolution 66-16

Diagnostic Services Palm Beach County Medical Society

Whereas, The medicare law makes the deductible for out-patient diagnostic services smaller if these services are performed in a hospital, and

Whereas, These diagnostic services are available and are customarily frequently performed outside the hospital in a skilled and economically competitive way; now therefore be it

RESOLVED, That all physicians of Florida continue to obtain diagnostic services for their patients from that facility which best provides these services for his patients without regard for whether these services will be paid

from medicare funds, private insurance funds, or directly from the patient.

Dr. Murray: "The Committee considered resolution 66-20, Payment to Anesthesiologists by Government Agencies, and recommends that it be approved with the exception of the deletion of the fifth paragraph.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Resolution 66-20

Payment to Anesthesiologists by Government Agencies Board of Governors

Whereas, remuneration to anesthesiologists for care of patients under PL 569 (popularly known as Medicare for dependents of Armed Forces personnel) is generally inadequate in many states, established on a fixed procedural basis rather than the most recent Relative Value studies, and has remained unchanged for many years, and

Whereas, Most medical fee schedules supported by State and County agencies throughout the United States are considerably below the usual and customary fees prevailing in the same areas, and

Whereas, Services other than medical care rendered by individuals to County, State or Federal governments or their agencies are usually reimbursed at the prevailing salary or fee for such services in that area, and

Whereas, Increasing government support and control of medical services and medical fees is evident and expected, not only for patients with low income, but for those with moderate and high incomes; therefore, be it

RESOLVED, That the Florida Medical Association go on record as strongly favoring the principle of payment for physicians' services by all government agencies and by government-sponsored or government-guided plans at all governmental levels, of the usual and customary fees prevailing in their area.

Dr. Murray: "The Committee considered resolution 66-22, Implementation of Tax Supported Medical Assistance for the Needy in Florida, and recommends that a new paragraph be added at the end as follows: 'It is intended that this arrangement is to be only a temporary subsidy created for the purpose of initiating the program of Tax Supported Medical Assistance for the Needy in Florida, and it is approved for a period of one year only, at the end of which time it should be possible to make reasonably adequate actuarial studies so that the program then can be put on a sound financial basis.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded.

Dr. Andrews, of Lake: "The intent of this resolution is well justified. I believe, however, we should give this real deep consideration, particularly item (b) of section 3. This is a welfare program being sponsored by the government and we are planning to underwrite it and it seems to me

this is opening the door for fees by legislation, which is something that we are definitely against. I move that item (b) of section 3 be deleted."

Motion was seconded.

Dr. Hampton: "I believe the reason given for deleting item (b) is the reason it should be included. This is to permit us to have our own method of payment to physicians and regulating the fees and to prevent just the eventuality that Dr. Andrews spoke about of having the government establish a fee schedule and restrict it by set regulations. This is a method which gives your Board of Governors the opportunity to negotiate and regulate and control the program. Without item (b) we have no method of doing this."

Dr. Flipse of Dade spoke against the amendment.

The amendment was defeated.

Motion to approve the recommendations of the Reference Committee was carried.

Resolution 66-22

Implementation of Tax Supported Medical Assistance for the Needy in Florida Board of Governors

Whereas, P. L. 89-97, requires all state welfare medical assistance programs eligible for federal participation in costs to provide by the end of 1969 five basic services equal in quality and availability to all welfare recipients and the needy sick (including the services of physicians in the home, office, or hospital);

Beginning 1 July 1966, the state of Florida will buy Voluntary Supplementary Medical Insurance for Aged Welfare Recipients under the provisions of Title XVI Social Security Law;

Payment of the deductible (initial \$50 costs annually) and 20% coinsurance is not provided by the state plan and cannot be reasonably related to the Aged welfare recipients income;

Equal medical services for the Blind and Disabled welfare recipients under Title XVI are not provided in the state plan;

The state medical assistance plan within the next three years must provide those medical services for the approximately 80,000 Aged, 20,000 Blind and Disabled and 200,000 welfare recipients in the category of Families with Dependent Children plus an indefinite number of needy sick in those categories just above income eligibility for cash subsistence grants;

Blue Shield has been designated the insurance carrier in Florida for Voluntary Supplemental Medical Insurance under the provisions of Title XVIII B, P. L. 89-97, therefore be it

RESOLVED, That the Florida Medical Association:

(1) Approve and actively support the provision of medical services to welfare recipients through agreement with the insurance carrier (Blue Shield) under the provisions of P. L. 89-97;

(2) Encourage the state of Florida to provide required medical services for welfare recipients through the insurance carrier for Voluntary Supplemental Medical Insurance, and, beginning 1 July 1966, insure payment of the deductible and coinsurance for VSMI for the Aged and equal physician services for the Blind and Disabled welfare recipients;

(3) Authorize the Board of Governors through the Florida Medical Foundation to:

(a) negotiate with the insurance carrier for the

provision of physician services to eligible welfare recipients within a reasonable insurance premium,

(b) Permit partial initial payment of fees to participating physicians for services rendered and holding the remainder of the fee in reserve for pro rata distribution at the end of each contract year, and

(c) Deduct from the reserve, sums for expenses and other expenditures approved by the Board of Governors.

It is intended that this arrangement is to be only a temporary subsidy created for the purpose of initiating the program of Tax Supported Medical Assistance for the Needy in Florida, and it is approved for a period of one year only, at the end of which time it should be possible to make reasonably adequate actuarial studies so that the program then can be put on a sound financial basis.

Dr. Murray: "The Committee considered resolution 66-23, Blue Cross-Blue Shield, and recommends that it not be approved because of the statement made by Blue Shield at the Blue Shield annual meeting on Thursday, which makes this resolution unnecessary. We encourage Blue Cross to follow the same pattern as that outlined for Blue Shield.

"Mr. Speaker, the Reference Committee recommends disapproval of resolution 66-23."

Dr. Sias: "Mr. Speaker, I wish to present the following substitute motion for 66-23 to give strength to the recommendation of the Reference Committee.

Substitute Resolution 66-23

"Whereas, Blue Shield of Florida at its annual meeting has agreed to continue in force its present policies for those over 65 who do not wish to participate in Medicare and to notify all of these policyholders to this effect as of their billing date in May 1966; and

"Whereas, Blue Cross of Florida has not agreed to continue its contracts for those over 65 who wish to keep them; therefore, be it

"RESOLVED, That the House of Delegates of the Florida Medical Association strongly recommend to Blue Cross of Florida that it take action parallel to that of Blue Shield of Florida."

Dr. Sackett: "As the one who introduced the original resolution, I am heartily in favor of Dr. Sias' substitute motion. I came to this meeting very much chagrined at the action of Blue Shield, not considering that Blue Cross was an even greater transgressor, and I think we should be very vigorous in our action toward Blue Cross."

Following a general discussion, the substitute motion was carried.

Dr. Murray: "The Committee considered resolution 66-26, Free Choice of Billing Method, and recommends it be approved as presented in the delegates' packets.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Resolution 66-26**Free Choice of Billing Method
Orange County Medical Society**

Whereas, Agencies of the Federal Government and fiscal intermediaries for medicare have extensively developed methods providing for doctors' billing via federal forms and rules, and

Whereas, Substantial numbers of doctors desire to bill patients directly for services, and

Whereas, No organized effort has been sponsored to facilitate this free choice of doctors as to billing method; therefore be it

RESOLVED, That the Florida Medical Association assist Florida doctors in developing and applying all methods of patient billing for medical services.

Dr. Murray: "The Committee gave a great deal of consideration to resolution 66-27, Medicare Admissions, and recommends that it be approved as presented in the delegates' packets.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Resolution 66-27**Medicare Admissions
Orange County Medical Society**

Whereas, Doctors of the Florida Medical Association believe in free choice of patients in all areas of medical care, be it therefore

RESOLVED, That the Florida Medical Association inform all hospital governing boards and all hospital medical staffs that the Florida Medical Association strongly believes that every patient should have the privilege of choosing whether or not he is to be admitted as a Medicare patient, and be it further

RESOLVED, That the Florida Medical Association seek to implement this position as a matter of policy.

Dr. Murray: "The Committee considered resolution 66-31, Definitions of Usual, Customary, Reasonable and Prevailing. The Committee has a certain reluctance to give rigid definitions to terms related to a situation as unsettled as that with which these terms are concerned; however, we are using the terms 'usual,' 'customary,' and 'reasonable' in other resolutions and we think that we must define them at least as we understand them now. With the understanding that the usage and definitions of these terms will be re-examined by the House of Delegates next year, the Committee accepts the definitions of 'usual,' 'customary,' and 'reasonable' as set forth in Resolution 66-31.

"The term 'prevailing fee' is another matter. The Committee believes that this term cannot properly be defined at this time and since the concept of prevailing fee is only under study by

Blue Shield of Florida, it does not require to be defined at this time. The definition of prevailing fee, therefore, is deleted from the resolution and referred to the Board of Governors with the suggestion that it be re-examined by the House of Delegates next year.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Resolution 66-31**Definitions of "Usual," "Customary,"
"Reasonable."
Broward County Medical Association**

Whereas, All reference committees of the 1966 meeting of the House of Delegates of the Florida Medical Association will be concerned with discussions of "usual," "customary," "reasonable" and "prevailing" fees, and

Whereas, There is no common acceptance of these terms among physicians, agencies and companies interested in the economics of medicine, and

Whereas, Three of these terms have been presented to the House of Delegates of the AMA, to wit:

"Usual: that fee usually charged for a given service by an individual physician to his private patient" (i.e., his own usual fee).

"Customary: a fee is customary when it is within the range of fees usually charged by physicians of similar training and experience, for the same service within the same specific area, and limited geographic area" (socio-economic area of a metropolitan area or socio-economic area of a county).

"Reasonable: a fee is reasonable when it meets the above two criteria, or in the opinion of the responsible medical association's review committee, is justifiable, considering the special circumstances of the particular case in question," therefore be it

RESOLVED, That the House of Delegates of the Florida Medical Association adopt these definitions as official guidelines of the Association.

Dr. Murray: "The Committee considered resolution 66-34 submitted by Dr. Jack Q. Cleveland regarding the Florida Medical Political Action Committee and recommends that it be approved.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded.

Dr. Everett Shocket, of Dade: "I move to amend the motion by deleting the first two paragraphs of this resolution and deleting the word 'conservative' in the third paragraph."

Amendment was seconded.

After discussion, the amendment was defeated.

Motion was carried to approve the recommendation of the Reference Committee.

Resolution 66-34**Endorsement of AMPAC and FLAMPAC**
Jack Q. Cleveland, M.D.

Whereas, It has been shown that the practice of medicine is being continually affected and further controlled by Federal laws enacted by a liberal Congress; and

Whereas, It is becoming more essential every year that the medical profession be involved in the election of a conservative Congress; and

Whereas, The American Medical Political Action Committee (AMPAC) and the Florida Medical Political Action Committee (FLAMPAC) have been organized for the purpose of (1) educating the profession on political matters, and (2) seeking to influence the election of conservative Congressmen from every state; and

Whereas, Political action committees are receiving the support and endorsement of the profession in other states, therefore be it

RESOLVED, That the members of the Florida Medical Association in regular session assembled, do hereby endorse the aims and purposes of AMPAC and FLAMPAC; and be it further

RESOLVED, That the members of the medical profession are urged to support those organizations in the interest of the continuance of the free practice of medicine in this state.

Dr. Murray: "Mr. Speaker, I move the adoption of the Committee's entire report as amended."

Motion was seconded and carried.

Dr. Richard M. Fleming, of Dade: "May I move that we reconsider the report of the Council on Specialty Medicine and strike recommendation No. 1, Prevailing Fee Concept Program, as it is inconsistent with other actions of the House?"

Dr. Steward: "I do not think there is any contradiction here. This is merely to continue the study of the prevailing fee program."

Dr. Zellner: "I would like to speak against reconsideration. Blue Shield has something like 2,800 replies. These replies are the property of the Florida Medical Association. Blue Shield has no intention of using them for any purpose except study. We are all aware that our relative value study has many inconsistencies and the results of this survey will be of invaluable assistance to the Fee Schedule Committee."

Motion to reconsider was defeated.

The Speaker interrupted the proceedings of the House to present a distinguished visitor, the Honorable Haydon Burns, Governor of the State of Florida.

In his introduction of the Governor, Dr. Hampton explained how Florida has provided funds for the health care of its needy in the past and the possibilities for this care under Title XIX of Public Law 89-97. He stated that the Florida Legislature in advance of the passage of this law had passed a bill enabling Florida to appropriate funds for the purchase of voluntary in-

surance for the aged welfare recipients, of which there are about 80,000 in this state, with a restricted contingency fund for other medical assistance programs. Dr. Hampton spoke of the difficulties faced by the Welfare Board in implementing these programs and the Governor's willingness to discuss these problems with the doctors of Florida.

Governor Burns spoke of the complications of the Medicare Law and the difficulties of making an estimate of its cost. He stated that the legislature had provided an appropriation to buy the voluntary supplemental insurance for its welfare recipients over 65 years of age, but had been confronted with the regulations of the Department of Health, Education, and Welfare, which ruled that the state could not do for one class of welfare recipients that which it did not do for all classes of welfare recipients; namely, those under 65 years of age, and those in the category of dependent children. The appropriations thus far made, he said, were not adequate to meet the financial demands of this broader program. After numerous conferences, a decision was finally reached which will allow the state to proceed with the implementation of the purchase of voluntary insurance for the aged welfare recipients. He complimented Dr. Hampton on his work as chairman of the Advisory Committee, and stated there was only one area in which he and Dr. Hampton were not in agreement. That area depends upon a decision by the Attorney General as to whether or not the provisions of the legislative act are broad enough to encompass all welfare recipients, and if so, the money is far short of that which would be required.

Governor Burns spoke of the shortage of hospital beds which will become more critical with the implementation of Medicare and suggested the further development of services on an outpatient basis to hold the physical hospitalization to the barest minimum that can be achieved.

The Governor cautioned that full implementation of the program would depend upon the will of the 1967 Legislature, which, in turn, will depend upon the will of the people. He thought every effort should be made in the next 18 months to educate the people of Florida concerning these programs.

In closing the Governor thanked the House for the invitation to appear before it and for the overtures of cooperation which have been made by the Florida Medical Association through its

chosen representatives. He assured the House that the state government would make no move that does not meet wholly the accord of the Florida Medical Association.

Dr. Hampton asked the unanimous consent of the House to present new business of an urgent nature, which was granted.

Dr. Hampton: "Senate Bills 2322 and 3059 of the 89th Congress, with reference to regulating the sale, transportation and handling of laboratory animals is now pending committee consideration. The American Medical Association supports the purposes of the provisions of this legislation which affords protection to owners of cats and dogs from the practice of pet stealing.

"Therefore, I would like to move that the Florida Medical Association concur in the position of the American Medical Association, and further, that our Association go on record as being opposed to further amendments which would provide licensure of research facilities and the setting of restrictive regulatory standards thereof."

Motion was seconded and carried unanimously.

The exhibit visitation awards were announced: First prize—Dr. Sullivan G. Bedell, of Jacksonville, \$150.00; second prize—Dr. John J. Fisher, of Jacksonville, \$100.00, and third prize—Dr. Edward W. Stoner, of Oviedo, \$50.00.

The winners of the Golf Tournament were announced: The Duval Trophy for low net score was won by Dr. Curtis D. Benton Jr. of Fort Lauderdale; the Orlando Loving Cup for low gross score was won by Dr. Joseph W. Pilkington of St. Petersburg.

Dr. Unger: "I rise to ask this body to seriously consider the import of its action taken with regard to FLAMPAC and AMPAC. I believe we are in danger of alienating our representatives who label themselves other than conservative. I think we should let all of our representatives know we are asking their support, and I ask for reconsideration of this action."

Motion was not seconded and no action was taken.

The Speaker announced that it was now time for election of officers and asked for nominations for President-Elect.

Dr. Sias: "Mr. Speaker, Fellow Members, Ladies and Guests: In the last 30 years on only three occasions has the Orange County Medical Society presented one of its members for election to the office of President-Elect of the Florida Medical Association. The men we have presented

to you in the past have been men who have proven themselves in service to their community, to their county medical society, and to the Florida Medical Association. In each instance we knew from previous performance that they would make outstanding presidents of this Association. Once more we are presenting to you such a man in Dean Steward.

"Dr. Steward is a native Georgian, receiving his education in the public schools of Georgia and his medical degree in 1936 from the University of Georgia. His internship and residency training was interrupted by five and a half years' service in the Army during World War II. After completing his residency in Internal Medicine at Jefferson Hospital in Philadelphia, he entered the private practice of Internal Medicine in Orlando in 1946. A year later he formed a partnership with Drs. Meredith Mallory and Fred Mathers with whom he still practices.

"He has been active in service to medicine since his arrival in Orlando. He is a past president of the Orange County Medical Society, past president of the Orange County Heart Association, past president of the Florida Society of Internal Medicine, past Chief of Medicine at Orange Memorial Hospital, and currently on the Senior Attending Staff. He has been a perennial delegate to this House of Delegates. He has been a member of the Blue Shield Board of Directors for the past seven years, and for the past three, he has been president of Blue Shield. Dr. Steward is currently a member of the Board of Governors and has previously served as chairman of the Council on Special Activities. His lovely wife, Martha, is a past president of the Auxiliaries of the Orange County Medical Society and the Florida Medical Association.

"An active member of the First Presbyterian Church, Dr. Steward is a former deacon, past chairman of the Board of Deacons and currently an Elder. He is past president of the Orlando Rotary Club. In his many positions of leadership, Dr. Steward has demonstrated time and again his mature judgment and responsibility in action.

"As of the present moment the Orange County Medical Society has 370 members. To my knowledge, there is not a single member who does not support the candidacy of Dr. Steward for this office. Those of us who know this man best, who work with him daily, who know his devotion to his profession, who have observed his practice and the way he handles his patients, those of us who

know the esteem with which he is held in our community, in short, those of us who know him best, know the great contribution he can make to this Association.

"Mr. Speaker, we wholeheartedly and unreservedly place in nomination for the office of President-Elect and President, Dr. Dean Steward."

Dr. Edward W. Cullipher, of Dade: "Mr. Speaker, Ladies and Gentlemen: About three months ago, I had a call asking me to nominate Dr. Dean Steward at this meeting. My refusal to do so was because, like Avis, if second we have to try harder.

"There is no need to belabor Dr. Steward's qualifications for this office. All of us make footprints on the sands of time. Some leave the impression of a great soul. I would like personally to second the nomination of Dean Steward for President-Elect of the Florida Medical Association."

Dr. Samuel G. Hibbs, of Hillsborough: "For the sake of brevity, I would just like to say I have known W. Dean Steward from Orange County for 20 years and it is certainly a privilege to be the representative from my county to second the nomination of this gentleman."

Dr. William H. Keeler III, of Pinellas: "I spoke last year in the House of Delegates about the quality of leadership. I would ask you to look before you at the quality of leadership we now have and look over the list of past presidents and note the quality of leadership we have had in the past.

"We are facing a time of great trial and difficulty and we need leadership. Dean Steward has proven to this Association, not only by his actions as a perennial delegate, but also as a member of the Board of Governors and President of Blue Shield of Florida that he is a man of unquestioned leadership ability.

"It is my very great honor and distinct privilege to second the nomination of Dean Steward for the office of President-Elect of the Florida Medical Association."

Dr. Emmet F. Ferguson Jr., of Duval: "Several of us were talking about Dean Steward the other day, and someone mentioned how appropriate his name is. He is the 'dean' of his profession and the 'steward' of its principles. I second the nomination of Dean Steward for President-Elect of the Florida Medical Association."

On motion duly seconded and carried, nomina-



Dr. W. Dean Steward of Orlando addresses the House of Delegates following his selection as President-Elect.

tions were closed and the Speaker declared Dr. Steward elected President-Elect.

Dr. Robert E. Zellner and Dr. Edward W. Cullipher escorted Dr. Steward to the rostrum.

Dr. Steward: "Mr. Speaker, Fellow Delegates, Members of the Florida Medical Association and Guests:

"I feel like the man, come Judgment Day, who rose up out of his grave, looked around, read the inscription on his tombstone and said, 'I think somebody is in the wrong hole.'

"In my 50 odd years of life I have had many nice things happen to me, most of them, I felt, undeserved. When Martha Boyd consented to become my wife was one of those nice things I have never been able to figure out. Another was when I was nominated and elected an Elder in the Presbyterian Church. Now comes this honor, which is greater than anything that I have had or have anticipated, and what makes it even nicer, it was given on the recommendation of my own county society and the men who know me better than anyone else.

"I can only say I thank you. I will do my best, and hope you will not be disappointed."

The Speaker asked for nominations for Vice President.

Dr. Cole: "It is with a great deal of pleasure that I place in nomination on behalf of the Pinellas County Medical Society the name of our President, William J. Dean, for Vice President of the Florida Medical Association.

"He was born in Atlanta, Georgia in 1924, attended the public schools in St. Petersburg,

completed his premedical education at Emory University and received a degree of doctor of medicine from Emory in 1948. He served his internship and residency in Internal Medicine at Emory University Hospital and Grady Memorial Hospital. He served in the Korean War as captain and major in the Medical Corps of the U. S. Army. Bill Dean has practiced in St. Petersburg since 1954. He is a Diplomate of the American Board of Internal Medicine, has served on many committees for the Pinellas County Medical Association and the Florida Medical Association and for many civic organizations. He has served for the past three years as a Director of Blue Shield of Florida and Tuesday was re-elected for a second three year term. He was secretary of his county medical society for several years and is now its president.

"Organized medicine in America today is engaged in a battle with socialism and it is imperative that the leadership of the Florida Medical Association continue in the hands of dedicated men who have the strength of character, the maturity of judgment and the energy to be effective. Such a man is Bill Dean.

"Mr. Speaker, on behalf of the Pinellas County Medical Association it is my privilege to place in nomination the name of William J. Dean."

The nomination was seconded by Dr. Richard C. Dever of Dade, Dr. James A. Winslow of Hillsborough and Dr. Arthur J. Moseley Jr., of Polk.

On motion duly seconded and carried, nominations were closed and the Speaker declared Dr. Dean elected Vice President.

Dr. Dean: "Mr. Speaker and Fellow Delegates: I do not plan to make a speech, but I sincerely appreciate the honor this House has given me and my county medical society. I will do all I can to carry out the business of this Association in the manner you would like it to be carried out and I thank you."

The Vice Speaker called for nominations for Speaker of the House.

Dr. Walter E. Murphree, of Alachua: "I wish to point out to you the words used by the Reference Committee in its report on the remarks of the Speaker, 'admirable and efficient conduct of the meeting.' It is my privilege and pleasure to place in nomination the name of Dr. Franklin J. Evans for Speaker of the House."

The nomination was seconded by Dr. Edwin P. Preston of Dade.

On motion duly seconded and carried, nominations were closed and the Vice Speaker declared Dr. Evans elected Speaker of the House.

The Speaker asked for nominations for Vice Speaker.

Dr. Frederick Andrews of Lake nominated Dr. James T. Cook.

The nomination was seconded by Dr. William F. Brunner of Jackson-Calhoun.

On motion duly seconded and carried, nominations were closed and the Speaker declared Dr. Cook elected Vice Speaker of the House.

The Speaker asked for nominations for the office of Secretary-Treasurer.

Dr. Wade S. Rizk, of Duval: "Mr. Speaker and Fellow Delegates: It is with great pleasure personally and on behalf of the Duval County delegation that I present in nomination for the office of Secretary-Treasurer, the name of Floyd K. Hurt, who has so ably conducted the duties of this office for the past two years. I commend to you very strongly Floyd K. Hurt for another term as Secretary-Treasurer of the Association."

Nomination was seconded by Dr. David Kirsh of Dade.

On motion duly seconded and carried, nominations were closed and the Speaker declared Dr. Hurt elected Secretary-Treasurer.

Dr. Hurt: "Thank you very much, gentlemen. My first reaction would be that I have no comment, but in view of the amenities of the situation, I should acknowledge Harold Parham and his excellent staff who have given me tremendous support in this position and I know I can count on him in the future. Thank you very much."

The Speaker called for the election of three delegates and three alternates to the House of Delegates of the American Medical Association for two year terms beginning January 1, 1967 and expiring December 31, 1968.

On nominations duly made and voted upon, the following were elected: Reuben B. Chrisman Jr., M.D., Delegate; Samuel M. Day, M.D., Alternate; Francis T. Holland, M.D., Delegate; Madison R. Pope, M.D., Alternate; Jere W. Annis, M.D., Delegate; Leo M. Wachtel, M.D., Alternate.

The Speaker called attention to the Board of Governors' nominations for the Committee on Membership and Discipline as listed in the Handbook.

As there were no additional nominations, motion was carried that nominations be closed and



Dr. George S. Palmer of Tallahassee, incoming President, is presented personal gavel of authority by outgoing President Dr. H. Phillip Hampton.

the Speaker announced that the following were elected:

District 1	
J. Wayne Hendrix, M.D., Port St. Joe	1970
District 2	
Thomas M. Irwin, M.D., Jacksonville	1970
District 3	
Harold Rand, M.D., Miami	1970
District 5	
John J. Cheleden, M.D., Daytona Beach	1970
District 6	
William H. Proctor, M.D., West Palm Beach	1970
District 7	
John M. Butcher, M.D., Sarasota	1970

Dr. Hampton: "Dr. Palmer, it gives me a great deal of pleasure to present this gavel to Dr. George S. Palmer, President 1966 of the Florida Medical Association. I would recommend that you wield it with authority. This year, they have changed things so that the President gets a certificate, rather than when he becomes Past President. I, therefore, present to you this President's Certificate."

Dr. Palmer: "Phil, now it is my turn. By presenting to you this Past President's pin, you join an elite company. It is an indication of your past presidency to be proudly worn with the esteem of the Association and heralds your entrance into a group of eminent predecessors. Chapter XVIII is over, but we still have XIX coming up. In turn, I will present to you the President's Certificate which has listed on it all of our eminent presidents.

"We have another presentation. Dr. Sanford Mullen has the floor."

Dr. Mullen: "During the past year the pathologists have become aware of the outstanding job done by our President, Dr. Hampton, and we

realize our group is only a small part of this Association and if the amount of work he has done to help us is any indication, it is a wonder he was ever in Tampa."

Dr. Mullen read the text of the certificate.

Dr. Palmer: "I request Dr. Warren W. Quilian and Dr. Samuel M. Day to escort Mrs. Hampton to the rostrum."

Dr. Palmer: "Kay, I want to give you this big picture of a very big man. The only consolation I can give you is that it will not talk back to you."

Dr. Palmer: "Putting first things first and the most important people in their proper place, I proudly present my wife, my partner in progress, and partner in the presidency, the one who has given me aid, comfort, companionship and inspiration for 23 years, and I hope she will stick with me in the coming months, one of the most wonderful and unselfish persons I have ever known, and I think our five children share in that opinion—Marie Palmer.

"I treasure and appreciate this honor that my fellow physicians have given me. To serve as your President and thus to represent our Association not only fills me with pride and determination but also scares me. If it is good to run scared, then I am good. Unfortunately, I am not at this moment magically endowed with more intelligence or with answers to all of the problems that confront me. I am an average man who will do his best to rise to the occasion and serve you well. I cannot and do not expect to know and do every-



Dr. George S. Palmer of Tallahassee addresses the House of Delegates after his installation as President of the Association.



Dr. George S. Palmer of Tallahassee presents photograph of Dr. H. Phillip Hampton to Mrs. Hampton as one of his first official acts after being installed as President of the Association.

thing. One must delegate responsibilities and tasks and those so called upon should respond readily. This is especially true of our council and committee chairmen and committee members. Each and all of us must be willing to sacrifice and give of time, money and energy. We can do no less. Many can do much more. Let us act as fellow physicians and as ethical and honorable ladies and gentlemen in a noble and dedicated profession. Let us not act as narrow-minded individuals pursuing selfish interests, either personal or material, in our chosen specialty or field.

"Beset by imminent changes which are frustrating and contrary to our principles and patterns of thought and professional behavior, we must ever remember that our future actions must be guided by one motivating influence—what is best for our patients—and at the same time follow our self-imposed Code of Ethics. Laws may change but medical ethics and our reason for being do not change. Providing quality medical

care for our patients is our reason for being. With this uppermost in mind, we can meet, adjust to and try to modify and overcome the many obstacles which are ahead and which to many of us now appear insurmountable and incompatible with the practice of medicine in the hands of physicians and not allow it to fall by default under control of the hospitals or any segment of government. May I remind you again that we are physicians first? May God guide our hearts and minds and hands in our continued and constant pursuit of excellence."

Dr. Palmer read the list of appointments to the Board of Governors, which will be found on the Officers and Committee pages of this Journal. He announced that the post-convention Board meeting would be held in the Embassy Room immediately following adjournment of the House.

Dr. Joseph A. Shelley pronounced the benediction.

The meeting was adjourned at 1:40 p.m.

President's Page



Our Moral and Professional Conduct

Medicare is in effect now and its vast, far-reaching and complicated machinery is in motion. Although we in organized medicine still believe that PL 89-97 is a bad law, we as physicians and as a profession have an obligation to do what is best for any of our patients who come under the law.

Our self-imposed Code of Ethics governs our moral and professional conduct. Adherence to our professional code assures conduct, both professional and personal, that is honorable, reliable and above reproach. By the same token it should not be unreasonable to expect the same sort of conduct from those responsible for administering PL 89-97. In other words, this law should be administered by the exact methods and means in order to bring about the clear intent which the Congress expressed when the law was written last summer. To change the original intent and purposes by administrative fiat is patently dishonest and a breach of faith and trust. Organized medicine and its representatives in the councils of government and bureaucracy must ever be vigilant to detect this type of subterfuge and do all we can to change and prevent it.

As Dr. Edward Annis said last fall, it is better to be in the enemy's camp and know what is going on than to be on the outside and know nothing.

George S. Palmer



when readings
indicate hypertension

Time for **Naturetin**[®] SQUIBB BENDROFLUMETHIAZIDE

to reduce blood pressure

In the management of your hypertensive patients, Naturetin is good therapy to start with, good therapy to stay with.

In mild hypertension, Naturetin lowers blood pressure gradually toward normotensive levels. In long-term therapy, Naturetin may keep blood pressure low—for months, sometimes years. When used in combination with other antihypertensive agents, blood pressure often falls further—and lower doses of both drugs are usually possible. Clinical trials have proven Naturetin effective—without serious side effects.^{1,2} And, when used to treat patients with cardiac edema and hypertension, "in no instance did the concentration of serum potassium fall below 3.1 mEq. per liter."³ (Normal range for serum potassium: 3.5-5.0 mEq./liter).⁴

When readings indicate hypertension, start with Naturetin, stay with Naturetin.

Contraindications: Severe renal impairment; previous hypersensitivity.

Warning: Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting, or G.I. bleeding occur.

Precautions: The dosage of ganglionic blocking agents, veratrum, or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Electrolyte disturbances are possible in cirrhotic or digitalized patients.

Side Effects: Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, and rashes may occur.

Supplied: Naturetin (Squibb Bendroflumethiazide) 5 mg. and 2.5 mg. tablets. Also available—Naturetin \bar{c} K (Squibb Bendroflumethiazide (5 or 2.5 mg.) with Potassium Chloride (500 mg.)). For full information, see Product Brief.

References: 1. Telfeyan, S. A.: Clin. Med. 70:166B, 1963. 2. Shepard, H. L.: J. Am. Geriatrics Soc. 11:363, 1963. 3. Cummings, D. E.; Goodman, R. M., and Steigmann, F.: J. Am. Geriatrics Soc. 12 161, 1964. 4. Castleman, B., ed.: New England J. Med. 268:1462, 1963.

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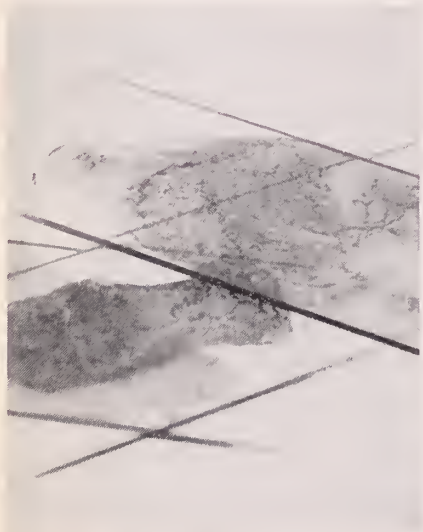
2. nonpregnant women with a history of recent
or recurrent monilial vaginitis



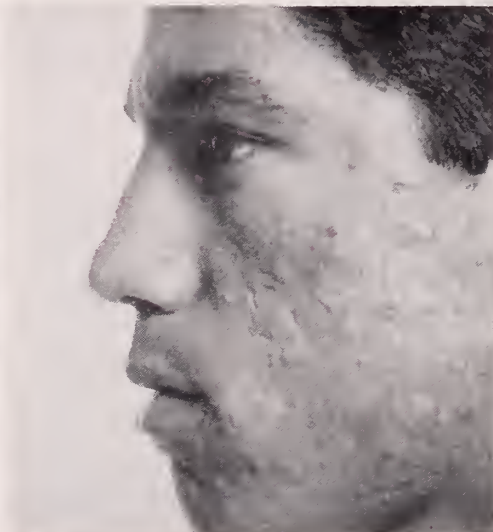
3. elderly or debilitated patients



4. patients with a past history of moniliasis



5. patients on long-term tetracycline or cortico-
steroid therapy



BRISTOL THERAPEUTIC SUMMARY: For complete formation consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced with tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discoloration occurs. No cases of photosensitivity have been reported with Tetrex (tetracycline phosphate complex). With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfection may occur. Infants may develop increased intracranial pressure with bulging fontanelles. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue therapy for 10 days in beta-hemolytic streptococcal infections. Administer 1 hour before or 2 hours after meals. *Supply:* Capsules, 16. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl and 250,000 units of nystatin.

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tetracycline-antifungal products.



Ninety-Second Annual Meeting

As is the custom following the wrap-up of an Annual Meeting, the Editor of The Journal of the Florida Medical Association requested an appraisal of the recent meeting. The following observations and comments are offered in response to this request.

General Format

Preregistration of the members of the House of Delegates was handled expeditiously. Reference committee meetings in the afternoon of the opening day and the publication of all reference committee recommendations by early afternoon of the day preceding the final session of the House of Delegates were both of help in the conduct of our business. Staggered reference committee meeting times continued to be of help to delegates and members with multiple interests.

The unusual excellence of the speakers who presented the Abel Seymour Baldwin Memorial Lecture at the General Session on Friday morning was noted and appreciated. Speakers of the caliber of Dr. Edward R. Annis and Dr. Ernest B. Howard make attendance mandatory for they impart the knowledge, the vision and the fervor necessary for the next year's work. It seems too bad that the House of Delegates of the Woman's Auxiliary was in session at the same time as this General Session. Our wives fully as much need the benefits derived from these speakers as do we.

The joining of FLAMPAC and the Woman's Auxiliary in the presentation of Chief Justice Millard Caldwell, as luncheon speaker on Friday, was an outstanding event. His historical approach and perspective enabled us to see many of our

present governmental and social problems in that perspective and we were stimulated to be more resolute in working for the solutions to these problems. A schedule permitting each of these speakers to start on time would have been in order.

The very excellence of these three gives answer to the previously voiced criticism, "What is in it for me at this annual state convention if I am not a delegate?" Similar national outstanding scientific speakers brought in by specialty groups for morning and afternoon sessions on Saturday would give further answer to this question.

The Scientific Assembly

The speakers and the arrangement of the subject material were well chosen. The presentations in general were precise and informative. The attendance seemed somewhat better than generally has been true in past years. Attendance can best be stimulated by the increased competence and caliber of the speakers. As an aside, improvement can be made in the choice of slides that can be seen and in the use of flashlight pointers for the projected slides that will work. Attendance will be helped also by running the sessions meticulously on time.

The scientific exhibits were unusually good. The interest displayed in these exhibits by the members seemed to be at an increased tempo throughout the meeting.

Several of the technical exhibitors were questioned as to the response they were having and with but one dissension they agreed that they

were being accorded considered attention by a goodly number of our members and guests.

Blue Shield

The Blue Shield meeting revealed the partial release of an accumulation of frustrations of 20 years' standing. Because of this display the guest speaker was not accorded sufficient attention or time. Placing the speaker first on the program at the Blue Shield meeting might be of some help.

Because of the divergent courses and philosophies of Blue Cross and Blue Shield, serious consideration might well be given to obtaining a highly qualified and paid full time executive secretary for Blue Shield alone and perhaps further thought might be given to the complete physical

separation of Blue Shield from Blue Cross. The question of the possible premature issuance of 170,000 complementary Blue Shield contracts, and secondly that of whether or not Blue Shield is to act as the fiscal agent for Medicare, might well have been better answered, and might well be better answered by a Blue Shield executive secretary acting in conjunction with our Blue Shield Board.

As a concluding note, let us all join together in the promotion in our organization of the primacy of scientific endeavor and achievement, for this is our field of competence.

JOHN M. BUTCHER, M.D.
SARASOTA

What To Do On July First

Editor's Note: The opinions expressed in the following editorial are those of the author, Joseph C. Von Thron, M.D., and do not represent official policy of the Florida Medical Association.

T.M.

At the recent FMA meeting, the House of Delegates passed a resolution embodying the principles of being a conscientious, ethical, practicing physician. The preface referred to the new Medicare law and essentially restated our position, that each physician's sole obligation is his relationship with his patient, and that no arrangement between government and citizen should directly or indirectly interfere with this association. Regardless of outside forces, we should continue to offer the best possible medical services. Each doctor should provide medical care, and in turn, bill his patient directly for just compensation. Another epigram advised each member to continue submitting his own statement and receive his own remuneration as a principle of good medical ethics.

The major paragraph states, and we quote, "It is recommended, inasmuch as the agreement for financial responsibility is between the patient and the government, that the physician not accept any assignment form." The Department of Health, Education, and Welfare requires the patient to complete Part I of Request for Payment, and the physician Part II. In referring to Part

II, however, the form explains, "This part, including physician's signature, need not be completed if paid and itemized bills are submitted."

This evokes no new principle, but permits each physician to revert back to his former position, obviating third party intervention. The feasibility of this approach, because many lack necessary funds, has commanded considerable attention over the last few months.

Solutions include:

- (a) Passive action manifested by continuing gratis therapy of this group.
- (b) Signing a receipted bill, with hope of collecting.
- (c) Suggesting a bank loan with assignment to the Bank.

These solutions, complicated as they are, certainly cannot be satisfying to both parties involved.

The physician can utilize the following agreement with the accompanying promissory note in exchange for a receipted bill. This promissory note serves as prima facie evidence of the debt and the amount will be recoverable in a court of law.

Agreement

THIS AGREEMENT made and entered into this the ____ day of _____, A.D. 1966, by and between JOHN DOE, hereinafter referred to as the "Doctor," and _____ hereinafter referred to as the "Patient."

Witnesseth:

WHEREAS, the Doctor has rendered professional services to the above named Patient and

WHEREAS, the Patient is indebted to the Doctor in the sum of _____ Dollars for professional services rendered, and

WHEREAS, the Patient is a subscriber of the Medical Insurance Program under the Social Security Act, and

WHEREAS, the Patient has paid for the benefits that he will receive under said Program, and, therefore, is personally entitled to the benefits to be derived from the Insurance Program, and

WHEREAS, the Patient is desirous of directly satisfying his obligation to the Doctor without adding a third party to the Patient-doctor relationship.

NOW THEREFORE, in and for the consideration of the Doctor giving a receipted bill to the Patient, evidencing satisfaction of the Patient's debt to the Doctor, the Patient does hereby agree to execute the attached promissory note representing the amount due to the Doctor.

IT IS HEREBY COVENANTED AND AGREED by and between the Doctor and the Patient that the Patient will forthwith make demand for reimbursement under his Medical Insurance Program.

IT IS FURTHER COVENANTED AND AGREED by the Patient that any and all proceeds which are received by the Patient from his Insurance Program as a result of the professional services rendered to him by the Doctor shall, within three days, be delivered to the Doctor in full satisfaction of the attached note.

Promissory Note

_____ 1966
For value received, the undersigned, jointly and severally, promise to pay to JOHN DOE, the sum of _____ Dollars. Said sum to be paid from any proceeds received by the maker under the Social Security Medicare Act. If not paid from the aforesaid proceeds, this note may be placed in the hands of an attorney at law for collection; and in that event, it is agreed and promised by the makers and endorsers, severally, to pay reasonable attorney's fees. Demand notice of non-payment and protest is hereby waived.

(SEAL)

(SEAL)

Due _____

The Agreement incorporating the promissory note serves as an example, and should be altered to fit the needs of the individual. We are complying, through this instrument, with the dictates of the administration; and, as such, preserving patient dignity. Collecting through his so-called prepaid insurance plan (Social Security), the patient can rightfully pay his own bills.

If each and every physician in Florida followed the receipted bill technique, using cash or a promissory note, the effect of Public Law 89-97 would be minimized. This would afford doctors the privilege of practicing under the policies and medical ethics long recommended for individual physicians by organized medicine.

Due to deductibles, however, the discrepancy between the promissory note and monies received may present an impossible obligation. Thus, one might hint adjustment could be made and the note destroyed after accepting the insurance proceeds as full satisfaction of the debt.

Incidentally, this approach may not only preserve the senior citizen's dignity, but also that of the American Doctor as well.

JOSEPH C. VON THRON, M.D.

FRANK M. WOLFE, ATTORNEY-AT-LAW
COCOA BEACH



"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine* specific differences in-

volving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to stay strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.





Board of Governors Actions Regarding Medicare

The Board of Governors on June 7, 1966, took the following actions regarding Medicare:

1. Requested Blue Shield of Florida, Inc. to sign a contract with the Secretary of the Department of Health, Education and Welfare for the purpose of carrying out the provisions of Section 1842 of the Social Security Act of 1965 providing for the use of carriers to administer Part B, Title XVIII. If the federal government changes the contract in any way that is inimical to the principles and policies of Blue Shield of Florida, Inc. or in any way that jeopardizes the close and compatible relationship between Blue Shield of Florida, Inc., the Florida Medical Association, and the physician-patient relationship, that the contract be cancelled as soon as practical or within 90 days.
2. The 90 day cancellation provision or whether to accept a contract without this provision be left to the President of the Florida Medical Association and the President of Blue Shield. These motions carried with two dissenting votes.
3. Objection was raised to Section IX, paragraphs A, B, C, pertaining to statistical information to be furnished the government in the proposed contract. It was agreed that Blue Shield attempt to delete these paragraphs in their negotiations.

Potential Hazard Warning

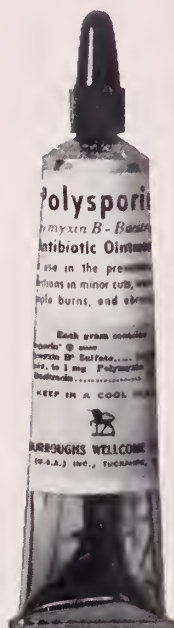
The attention of Florida physicians is called to the existence of a definite and as yet uncontrolled hazard. This hazard is the seemingly innocent open sale of morning glory (*Ipomoea*) seed packets.

When chewed and swallowed these seeds produce hallucinatory effects due to LSD-related compounds they contain.

The hallucinatory effect upon a young college student after ingestion of five packets of morning glory (*Ipomoea tricolor*) seeds was reported by Albert L. Ingram Jr., M.D., on page 1133 of the Dec. 28, 1964 issue of the Journal of the American Medical Association.

Brevard County newspapers in mid-May reported high school students buying these seeds in quantity until merchants were warned of the potential hazard.

in treating topical infections, no need to sensitize the patient



USE 'POLYSPORIN'[®] brand POLYMYXIN B-BACITRACIN ANTIBIOTIC OINTMENT

**broad-spectrum antibiotic
therapy with minimum risk
of sensitization**

Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **Contraindication:** This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: In ½ oz. and 1 oz. tubes

Complete literature available on request from Professional Services Dept. PML.



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Alcoholics treated. Aged adjudged cases will be accepted on
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A private institution for the treatment of nervous and mental disorders and the problems of drug addiction and alcoholic habitation. Modern diagnostic and treatment procedures including — Psychotherapy, Insulin, & Electroshock, when indicated. Adequate facilities for recreation and out-door activities.

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Member NAPPH and American Psychiatric Assn.

The Mediatrix Age:

There is a growing senescent body of people who—either from lack of motivation, or as a result of surgery, trauma, or extended illness—are on their way to malignant inactivity...



The Mediatrix Age:

Unfortunately, there is no cure. But there are, largely through your own interest and direction, ways to help them back to a more active and useful life. There are medicines, too, designed to help. One such has proved useful in clinical practice:

"A steroid-nutritional compound (Mediatrix) was used in 100 patients to relieve some of the symptoms caused by degenerative changes of aging . . . This therapy resulted in improvement of 75 per cent of the patients . . ."

McNeill, A. J.: Clin. Med. 8:518 (Mar.) 1961.

"Mediatrix (steroid-nutritional compound) capsules, one a day, seem to give definite help to debilitated patients."

Arnold, E. T., Jr.: Geriatrics 12:612 (Oct.) 1957.

"Nutritional and hormone bolstering of function in the aged may have a useful place in geriatrics."

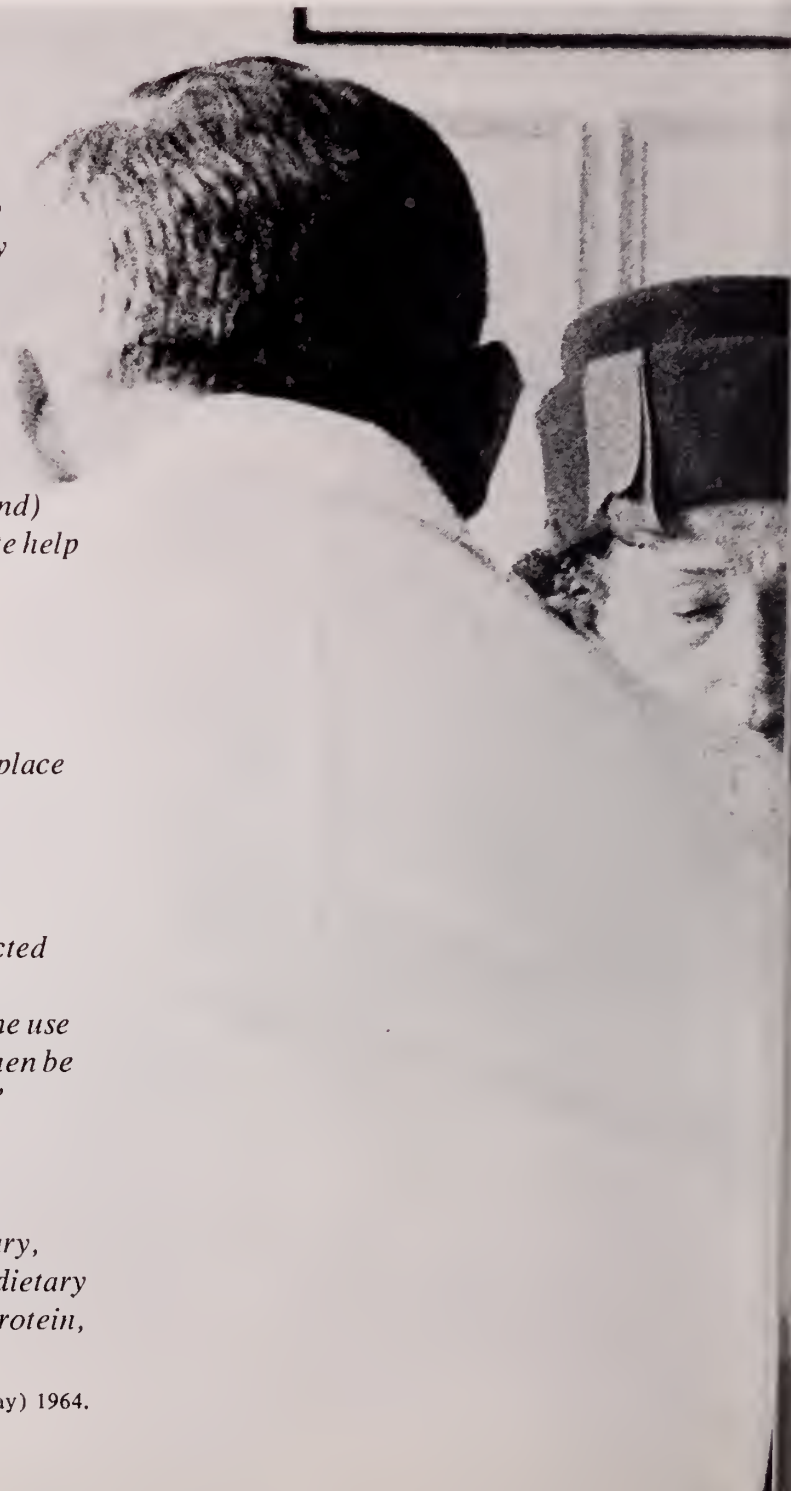
Morgan, A. E.: Gerontologist 2:77 (June) 1962.

"In diets which for any reason are restricted in calories, enough of these substances (B vitamins) may not be supplied . . . The use of B and C vitamin supplements may then be justified and indeed may be necessary."

Morgan, A. E.: Gerontologist 2:77 (June) 1962.

"Intensive nutritional therapy is necessary, especially in elderly people, to correct dietary deficiencies created by large losses of protein, vitamins and other nutrients."

Riccitelli, M. L.: J. Am. Geriatrics Soc. 12:489 (May) 1964.



Mediatric®

Designed for the “metabolically spent”

Nutritional reinforcement for those who can’t – or won’t – eat properly...balanced amounts of estrogen and androgen to counteract declining gonadal hormone secretion and its sequelae of premature degenerative changes...mild antidepressant for a gentle “mood” uplift...

The estrogen component in MEDITRIC is PREMARIN® (conjugated estrogens—equine), the natural estrogen most widely prescribed for its superior physiologic and metabolic benefits.

MEDITRIC also provides *nutritional reinforcement—blood-building factors and vitamin supplementation*. It contributes a *gentle “mood” uplift* through methamphetamine HCl.

Three different dosage forms—Liquid, Tablets, and Capsules—offer convenience and variety.

MEDITRIC Liquid

Each 15 cc. (3 teaspoonfuls) contains:

*Conjugated estrogens—equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
Thiamine HCl	5.0 mg.
Cyanocobalamin	1.5 mcg.
Methamphetamine HCl	1.0 mg.

Contains 15% alcohol

MEDITRIC Tablets and Capsules

Each MEDITRIC Tablet or Capsule contains:

*Conjugated estrogens—equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
Ascorbic acid	100.0 mg.
Cyanocobalamin	2.5 mcg.
Intrinsic factor concentrate	8.0 mg.
Thiamine mononitrate	10.0 mg.
Riboflavin	5.0 mg.
Niacinamide	50.0 mg.
Pyridoxine HCl	3.0 mg.
Calc. pantothenate	20.0 mg.
Ferrous sulfate excis.	30.0 mg.
Methamphetamine HCl	1.0 mg.

*Orally active, water-soluble conjugated estrogens derived from pregnant mares’ urine and standardized in terms of the weight of active, water-soluble estrogen content.

MEDITRIC helps keep the older patient alert and active; helps relieve general malaise, easy fatigability, vague pains in the bones and joints, loss of appetite, and lack of interest usually associated with declining gonadal hormone secretion.

CONTRAINDICATION: Carcinoma of the prostate, due to methyltestosterone component.

WARNING: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.

SIDE EFFECTS: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.

SUGGESTED DOSAGES: *Male and female:* 3 teaspoonfuls of Liquid, 1 Tablet, or 1 Capsule, daily or as required.

In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

SUPPLIED: No. 910 – MEDITRIC Liquid, in bottles of 16 fluidounces and 1 gallon. No. 752 – MEDITRIC Tablets, in bottles of 100 and 1,000. No. 252 – MEDITRIC Capsules, in bottles of 30, 100, and 1,000.



Mediatric®
steroid-nutritional compound

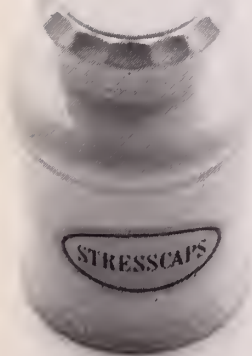


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B and C vitamins are therapy: Therapeutic amounts of B and C in stress formula vitamins often are vital during periods of physiologic stress. STRESSCAPS capsules, designed to meet increased metabolic demands, aid in achieving a more comfortable convalescence, a more rapid recovery. After surgery, as in many stress conditions, STRESSCAPS vitamins are therapy.



Stresscaps[®]
Stress Formula Vitamins Lederle



Each capsule contains:
 Vitamin B₁ (Thiamine Mononitrate) 10 mg
 Vitamin B₂ (Riboflavin) 10 mg
 Vitamin B₆ (Pyridoxine HCl) 2 mg
 Vitamin B₁₂ Crystalline 4 mcgm
 Vitamin C (Ascorbic Acid) 300 mg
 Niacinamide 100 mg
 Calcium Pantothenate 20 mg
 Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York



E27-6-30



makes sleep irresistible

nidar[®]

EACH TABLET CONTAINS:

Pentobarbital Sodium.....	25 mg.
Secobarbital Sodium.....	25 mg.
Butabarbital Sodium.....	7.5 mg.
Phenobarbital.....	7.5 mg.

(WARNING: MAY BE HABIT FORMING)



ARMOUR PHARMACEUTICAL COMPANY
Chicago, Illinois, U.S.A.

nidar®

Sleep comes easy...lingers...departs naturally

Gentle doses of 4 barbiturates assure uninterrupted sleep

2 barbiturates act fast...in 20 to 30 minutes

2 long-range barbiturates come into play
to sustain sleep for up to 8 hours

Tiny amounts of individual barbiturates
means Nidar is well tolerated

Patients enjoy a refreshing, clear-headed wake-up

makes sleep irresistible




IN BRIEF:

EACH TABLET CONTAINS:

Pentobarbital Sodium.....	25 mg.
Secobarbital Sodium.....	25 mg.
Butobarbital Sodium.....	7.5 mg.
Phenobarbital	7.5 mg.

(WARNING: MAY BE HABIT FORMING)

 Dosage: One or two tablets, one-half hour
before bedtime.

Indications: For night-time sedation and refreshing
sleep up to eight hours.

Contraindications: Patients sensitive to barbiturates.
Use with caution in the presence of moderate to severe
hepatic disease.

Supplied: Bottles of 100 tablets.

CAUTION: Federal law prohibits dispensing without
a prescription.



ARMOUR PHARMACEUTICAL COMPANY
Chicago, Illinois, U.S.A.

Need a
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jeweler!*

Need
another car?



*Visit your
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Need
optical services?



*Call on
an expert —*

YOUR GUILD OPTICIAN!

Just as the jeweler is trained in his field, and the auto dealer is knowledgeable in his business, the Guild Optician is an expert in *his*.

We say "Call on an expert . . ." because your local Guild Optician is an expert in mechanical optics. You know he is equipped to handle your most critical cases, both in experience and in training. You know also, because he is a Guild Member, that his standards are high, and that you can depend on him to accurately translate your patient's prescription and to render such after service as your patient might need, for the life of that prescription.

Your local Guild Optician also is an expert at working with your patient in an understanding manner when it comes to the styling and fit of your patient's frame. His stocks reflect not only the most modern fashions, but also the conservative styles that have lasted over the years.

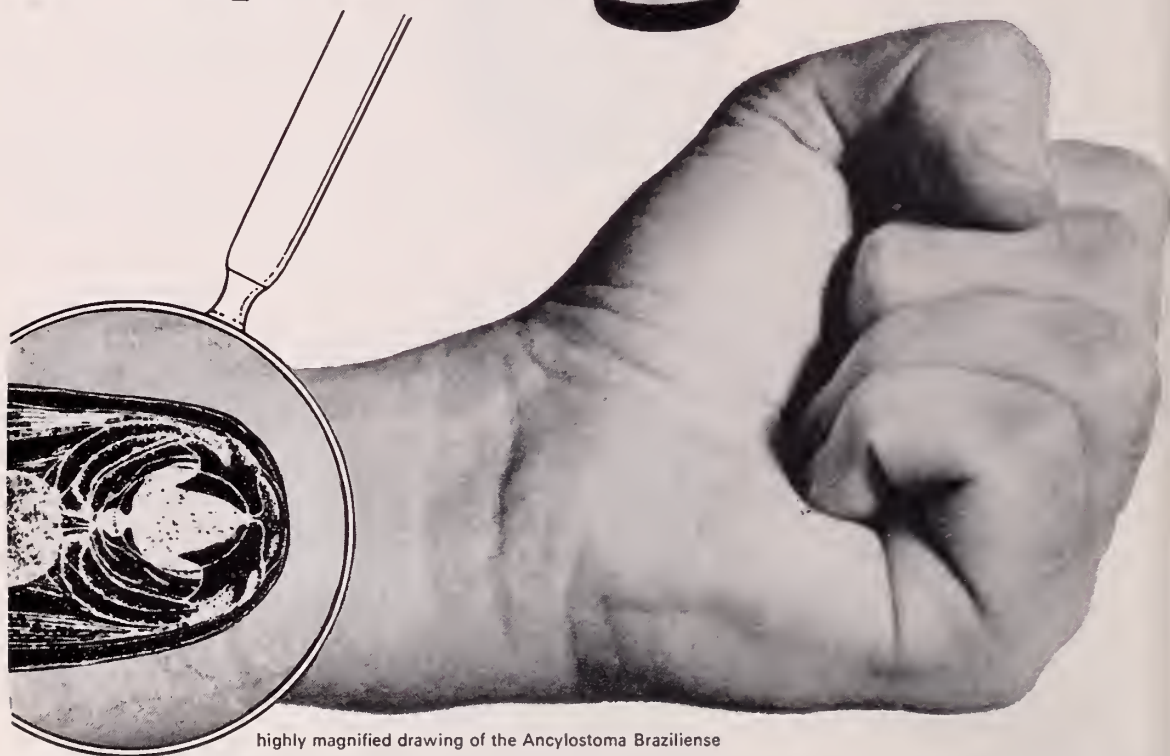
There are, of course, many other areas in which your Guild Optician may be highly skilled: sub-normal vision cases, aphakic cases, contact lenses.

When you need optical services, think first of your Guild Optician! *Guild of Prescription Opticians of Florida.*



USING GUILD SKILLS AND EXPERIENCE TO SERVE YOUR PATIENTS

Gebauer's Ethyl Chloride stops creeping eruption cold



highly magnified drawing of the *Ancylostoma Braziliense*

Creeping eruption is ugly, uncomfortable, and persistent. And, in Florida, it is seen with considerable frequency.

Creeping eruption is caused by the larvae of the dog and cat hookworm, *Ancylostoma Braziliense*. The larvae of this parasite burrow between the superficial layers of the skin, causing much discomfort and characteristic angry eruptions.

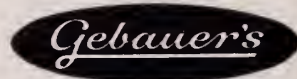
Happily, Gebauer Ethyl Chloride sprayed on the affected area for 30 seconds to one minute will usually kill the offending larvae. In difficult cases, it may be necessary to spray for a period of up to two minutes. Improvement and cure generally follow a comparatively few applications.

Next time you treat creeping eruption, treat it with Gebauer Ethyl Chloride. Also highly effective as a topical anesthetic for minor surgery, as in removal of splinters, incision of boils and whitlows, and to alleviate needle pain. May be used for relief of pain such as first and second degree burns, bee stings, sprains and muscle spasm.

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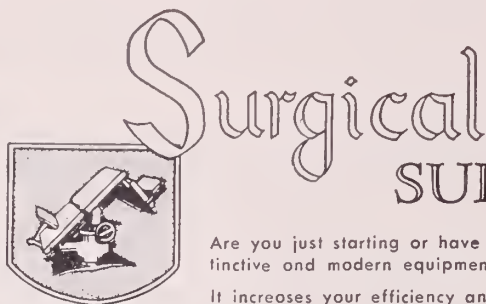
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**A patient centered
independent hospital for
intensive treatment of
nervous disorders . . .**

Hill Crest Hospital was established in 1925 as Hill Crest Sanitarium to provide private psychiatric treatment of nervous or mental disorders. Individual patient care has been the theme during its 41 years of service.

Both male and female pa-

tients are accepted and departmentalized care is provided according to sex and the degree of illness.

In addition to the psychiatric staff, consultants are available in all medical specialties.



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Hill Crest is fully accredited by the Joint Commission on Accreditation of Hospitals.

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HOSPITAL**
BIRMINGHAM, ALABAMA

Most of my patients with high blood pressure are as old as I am. A lot of them are living on pensions. They're grateful when I can keep prescription costs down.

Regroton®

chlorthalidone 50 mg, reserpine 0.25 mg.

One tablet daily
brings pressure down

Advantage: Both components of Regroton are long-acting.

Average dosage: One tablet daily with breakfast.

Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.

Warning: Discontinue 2 weeks before general anesthesia, 1 week before electroshock therapy, and if depression or peptic ulcer occurs. With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.

Precautions: Reduce dosage of concomitant antihypertensive agents by one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.

Side effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.

For full details, see the complete prescribing information.

Availability: Bottles of 100 and 1000 tablets.

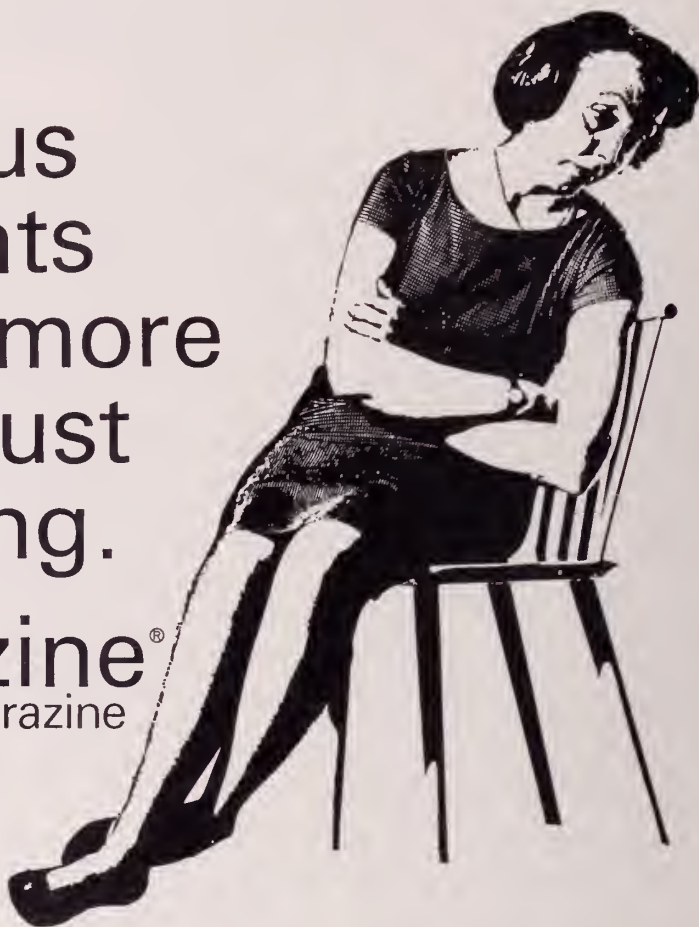
Geigy



Many
anxious
patients
need more
than just
calming.

Stelazine[®]
brand of trifluoperazine

offers
true
tranquilization.



Sedative or muscle relaxant-type tranquilizers are often all that's needed for patients with temporary situational anxiety. But in the many patients whose anxiety presents a continuing problem these agents are limited by their generalized dulling effects.

'Stelazine' can attack anxiety directly without producing annoying dulling effects. On 'Stelazine', patients can react more normally to day-to-day stress yet remain alert, able to carry on their normal activities.

Contraindicated in comatose or greatly depressed states due to CNS depressants and in cases of existing blood dyscrasias, bone marrow depression and pre-existing liver damage. *Principal side effects*, usually dose related, may include mild skin reaction, dry mouth, insomnia, fatigue, drowsiness, dizziness and neuromuscular (extrapyramidal) reactions. Muscular weakness, anorexia, rash, lactation and blurred vision may also be observed. Blood dyscrasias and jaundice have been extremely rare. Use with caution in patients with impaired cardiovascular systems. Before prescribing, see SK&F product Prescribing Information.



Smith Kline & French Laboratories, Philadelphia



An eminent role in medical practice

Clinicians throughout the world consider meprobamate a therapeutic standard in the management of anxiety and tension.

The high safety-efficacy ratio of 'Miltown' has been demonstrated by more than a decade of clinical use.

Miltown® (meprobamate)

Indications: Meprobamate is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, meprobamate fosters normal sleep through both its anti-anxiety and muscle-relaxant properties.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses.

Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

Supplied: 'Miltown' (meprobamate) is available in two strengths: 400 mg. scored tablets and 200 mg. coated tablets. 'Mepro-tabs' (meprobamate) is available as 400 mg. white, coated, unmarked tablets. *Before prescribing, consult package circular.*

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Night Leg Cramps... Frequent Bedfellow in Diabetes, Arthritis, and Peripheral Vascular Disorders*



"Nocturnal cramps occurring in the calf muscles and small muscles of the feet have been encountered in a significant number of diabetic patients."¹

"... nocturnal cramps may be the presenting symptoms of patients with arteriosclerosis obliterans, deep thrombophlebitis, varicose veins, osteoarthritis..."²

now...specific therapy for night leg cramps

QUINAMMTM

Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.³ Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose... helps restore restful sleep.

WALKER
Laboratories

QUINAMM Composition: Each white, beveled, compressed tablet contains: Quinine Sulfate 4 grains (250 mg.), Aminophylline 3 grain (200 mg.). **Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets. **Caution:** Federal law prohibits dispensing without prescription. **Reference:** 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuck, E., et al.: Angiology, 12:102, 1961. 3. Rowls, W. B., et al.: Med. Times 87:818, 1959.

Division of Richardson-Merrell Inc. Mt. Vernon, New York 1055

Doctor,

Here is the Abbott anorectic program designed to meet the individual needs of your overweight patients.



mood elevation

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DESOXYN® Gradumet® (methamphetamine hydrochloride)

Smooth appetite control plus mood elevation.

The obese patient on a diet often has to battle depression as well as overweight. Desoxyn Gradumet helps the dieter in both battles by elevating the mood while it curbs the appetite. Thanks to the Gradumet, medication is smoothly released all-day from a single oral dose.

If she can't take plain amphetamine put her on DESBUTAL® Gradumet

Calms anxieties; controls compulsive eating.

Desbutal Gradumet provides 2 drugs in 2 tablet sections, combined back to back to form a single tablet. One section contains Desoxyn to curb the appetite and lift the mood; the other contains Nembutal® (pentobarbital) to calm the patient and counteract any excessive stimulation.

Both drugs are released in an effective dosage ratio throughout the day.



controlled release

Abbott
Anorectic
Program

Not all long-release vehicles are the same. Here is why the Gradumet is different and what it means for your overweight patients.



The release action is purely physical and relies on only one factor common to every patient: gastrointestinal fluid. There is no dependence on enteric coatings, enzymes, motility, or an "ideal" ion concentration in the gastrointestinal tract.

Your patients get a measured amount of medication, moment by moment, throughout the day.

They are not subjected to ups and downs of drug release . . . or to erratic release from patient to patient . . . or to erratic release in the same patient from day to day.

That's why the Gradumet provides controlled-release as well as long release.



Perhaps you saw the Gradumet model demonstration which shows that the release is entirely physical. When fluid is added, the drug in the outer ends of the channels dissolves. As fluid penetrates deeper into the channels, there is a continuous release of medication. The rate of release is rigidly controlled by the size and number of channels.

choice of 5 strengths

Abbott
Anorectic
Program

DESOXYN Gradumet

Methamphetamine Hydrochloride in Long-Release Dose Form



5 mg.



10 mg.



15 mg.

DESBUTAL 10 Gradumet

10 mg. Methamphetamine Hydrochloride,
60 mg. Pentobarbital Sodium



Front



Side

DESBUTAL 15 Gradumet

15 mg. Methamphetamine Hydrochloride,
90 mg. Pentobarbital Sodium



Front



Side

samples available



Each sample contains 6 tablets and a filled Sucaryl® Sweetener dispenser. For a supply, write Abbott Laboratories or ask your Abbott man.

Desbutal 15 Gradumet

Product of choice for patients who overreact to plain amphetamine

As an anorectic in treatment of obesity also to counteract anxiety and mild depression. Desbutal is contraindicated in patients taking a monoamine oxidase inhibitor. Nervousness or excessive sedation have occasionally been observed when these effects will disappear after a few days. Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism or who are sensitive to sympathomimetic drugs. Careful supervision is advisable with maladjusted individuals.

A single Gradumet tablet in the morning provides all-day appetite control.

Desbutal 10 contains 10 mg of methamphetamine hydrochloride and 60 mg of pentobarbital sodium. Desbutal 15 contains 15 mg of methamphetamine hydrochloride and 90 mg of pentobarbital sodium in bottles of 100 and 500.

Sucaryl Sweeteners

A proven aid to weight control—

For use in beverages and foods—stable to heat

A constant reminder to your patient to "watch her calories"

A carefully balanced formula to prevent aftertaste

—in tablets and liquid—

Sucaryl—Abbott brand of low and non-caloric sweeteners

Press out tablets from this side

LOT NO. 784 1331



For:

Directions:

Dr.



PH 0175-10-1-1-1

economy

Patients, in many cases, save enough to get five weeks of medication for the price of four, compared to other leading long-release anorectics.

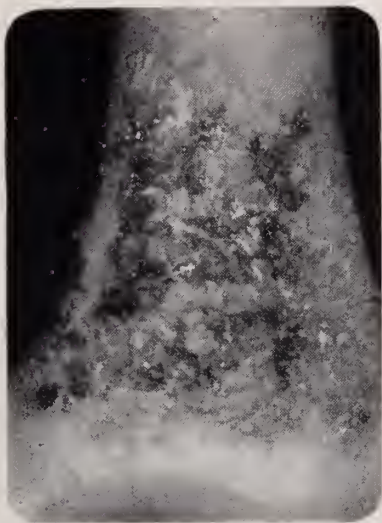
CONTRAINDICATION: Desoxyn and Desbutal are contraindicated in patients taking a monoamine oxidase inhibitor.

PRECAUTIONS: Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs or ephedrine and its derivatives. Careful supervision is advisable with maladjusted individuals.

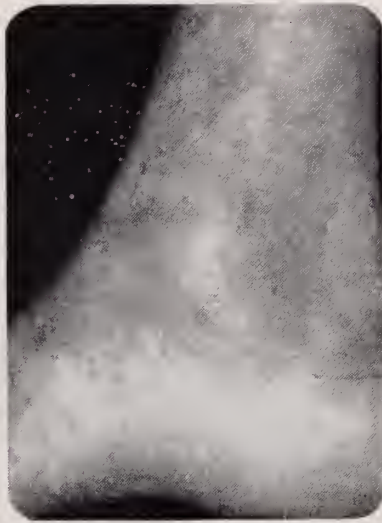


Gradumet—long-release dose form, Abbott U.S. Pat. No. 2,987,445.
Sucaryl—Abbott brand of low and non-caloric sweeteners.

eczema: scourge of childhood



R. R., Age 11—Before treatment—
atopic eczema of long standing



After treatment—with ARISTOCORT
Topical Ointment 0.1% for two weeks

ARISTOCORT® Triamcinolone Acetonide Topicals have been exceptionally effective in the control of various types of childhood eczema: allergic, atopic, nummular, contact, and mycotic.

Most cases responsive to topical ARISTOCORT, 0.1% concentration is sufficiently potent. The 0.5% concentration provides enhanced topical activity for cases requiring additional potency for proper relief.

Application and Dosage: Apply sparingly to the affected area 3 or 4 times daily. Some cases of psoriasis may be more effectively treated if the 0.1% Cream or Ointment is applied under an occlusive dressing.

Contraindications: Tuberculosis of the skin, herpes simplex, chickenpox and vaccinia.

Warnings and Side Effects: Do not use in the eyes or in the mouth (if drum is perforated). A few individuals react unusually under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate

measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyoderma will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

Packages: Tubes of 5 Gm. and 15 Gm.; 1/2 lb. jar.

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Topical Ointment 0.1% and Cream 0.1%, 0.5%
Triamcinolone Acetonide

Also available in foam form and with neomycin.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

For prompt, emphatic diuresis

aquaTAG[®]
(BENZTHIAZIDE)



NEW FROM TUTAG for prompt, comfortable diuretic action with a balanced excretion of sodium chloride and a lower potassium loss under normal dosage and diet regimen

DIURETIC ACTION: Clinically, the oral administration of AQUATAG (benzthiazide) results in diuretic activity within two hours with maximal natriuretic, chloruretic, and diuretic effects occurring during the fourth, fifth and sixth hours. Maintenance of response continues for approximately 12 to 18 hours. Acidosis is an unlikely complication since therapeutic doses of AQUATAG (benzthiazide) do not appreciably increase bicarbonate excretion. Edematous patients receiving 50 mg. of AQUATAG (benzthiazide) daily for five days developed a maximal increase in the rate of sodium excretion on the first day, and maintained this high rate until depletion of excessive body stores of sodium.

In congestive heart-failure patients, AQUATAG (benzthiazide) produced the same weight loss, during a 48-hour treatment period as did a maximally effective dose of hydrochlorothiazide.

DOSAGE: Diuresis, initially 50 to 200 mg., maintenance 25 to 150 mg., daily. Hypertension 50 to 100 mg. initially, adjusted to 50 mg. t.i.d. or downward to minimal effective dosage level.

PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia, hypochloremic alkalosis and hyponatremia may occur. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Insulin requirements may be altered in diabetes.

WARNINGS: Dosage of coadministered antihypertensive agents should be reduced by at least 50%. Use with caution in edema due to renal disease; advanced hepatic disease or suspected presence of electrolyte imbalance. Stenosis or ulcer of small intestine have been reported with coated potassium formulas and should be administered only when indicated. Until further clinical experience is obtained, the use of the drug in pregnant patients should be carefully weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or disfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties.

Before prescribing or administering, read the package insert or file card available on request.

Available as 25 or 50 mg. scored tablets.

Request clinical samples and literature on your letterhead.


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& COMPANY**
Detroit, Michigan 48234

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RICHMOND, VIRGINIA

A private hospital for diagnosis and treatment of psychiatric and neurological disorders. Hospital and out-patient services.

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EDWARD W. GAMBLE, III, M.D.
CATHERINE T. RAY, M.D.

Deaths

Brinson, John Bradford, Monticello; born in Madison, May 24, 1886, Atlanta Medical College, now Emory University School of Medicine, Atlanta, Ga., 1914; interned in a Baltimore hospital; returned to Florida where he engaged in the general practice of medicine in Monticello for more than 50 years; established the Brinson Medical Clinic; was a former secretary-treasurer and a past president of the Leon-Wakulla-Jefferson County Medical Society; was named Man of the Year in 1960 by the American Legion Auxiliary of Monticello and the Outstanding Citizen during the Monticello Annual Festival; in August 1965 was awarded a 25 year emblem for distinguished service by the Atlantic Coast Line; was a life member of the Florida Medical Association and held membership in the American Medical Association and the American Academy of General Practice; died January 19, aged 79.

Hotchkiss, Walter Thompson, Miami Beach; born in Jamestown, N.Y., Sept. 29, 1896; University of Michigan Medical School, Ann Arbor, Mich., 1921; served an internship and a residency at his alma mater; was associated with the Cleveland Clinic for a year and a half; came to Miami Beach in 1926, where he practiced his specialty of otolaryngology for four decades; was one of the founders of the medical staff of St. Francis Hospital and was head of the nose and throat department for many years; was a past president of the Miami Hard of Hearing Society and of the Florida Society of Ophthalmology and Otolaryngology; was a fellow of the American College of Surgeons; was a member of the American Medical Association, American Academy of Ear, Nose and Throat, Otological, Rhinological and Laryngological Society, and American Academy of Ophthalmology and Otolaryngology; was one of the organizers of the Florida Midwinter Seminar of Ophthalmology and Otolaryngology; died Dec. 26, 1965, aged 69.

Kyler, Stephen Leo, West Palm Beach; born in Czechoslovakia, 1910; Universita Komenskeho Fakulta Lekarska, Bratislava, Czechoslovakia, 1936; was an honorary foreign Assistant Professor of the Universite de Paris Faculte de Medecine; served during the Korean War in the Medical Corps of the United States Army with the rank of major; was chief of the Endoscopy and Pulmonary Clinic, Fitzsimmons Army Hospital, Denver, Colo., and later was Chief of the Ear, Nose and Throat Department of the Veterans Administration Hospital, Pittsburgh, Pa.; came to West Palm Beach in 1959 from the University of Pittsburgh School of Medicine; was a fellow of the American College of Surgeons and held membership in the American Medical Association, American Academy of Ophthalmology and Otolaryngology, American Thoracic Society, American Rhinologic Society for Plastic Surgery and American Academy of Facial Plastic and Reconstructive Surgery; died Dec. 12, 1965, of acute myocardial infarction, aged 55.

Moss, Herman, Jacksonville; born in Brooklyn, N.Y., Aug. 24, 1924; Marquette University School of Medicine, Milwaukee, Wis., 1947; served an internship at Monmouth Memorial Hospital, Longbranch, N.J., and an obstetrical residency at Wamsburgh Maternity Hospital, Brooklyn, 1947 to 1949; was an officer in the Medical Corps of the Navy from 1944 to 1946 and again from 1949 to 1952; came to Jacksonville in 1952; completed a one year residency at St. Luke's Hospital in 1953 and at St. Vincent's Hospital in 1954; engaged in the private practice of obstetrics thereafter in that city; was a member of the American Medical Association; died Dec. 18, 1965, after an illness of several months, aged 41.

Ring, Harold Henry, Chattahoochee; born in Manson, Iowa, March 3, 1897; State University

of Iowa College of Medicine, Iowa City, 1926; served an internship and a residency in University of Iowa Hospitals, 1926-1929; was instructor in the Department of Obstetrics and Gynecology, 1928-1930; practiced his specialty in Tucson, Ariz., 1930-1933; served in the Medical Corps, U. S. Army, with the rank of major, 1933-1943, retiring because of physical disability incurred in line of duty; engaged in maternal and child health work in Georgia and Florida, 1943-1950; was gynecologist, Florida State Hospital, Chattahoochee, 1950-1957; was director of the Madison, Jefferson, Taylor Health Unit, 1957-1959; served on the staff of the Milledgeville (Ga.) State Hospital, 1959-1962; retired because of ill health and returned to Chattahoochee in 1962; was a fellow of the American College of Surgeons, a founding member of the American College of Obstetrics and Gynecology, and a member of the American Medical Association and the Southern Medical Association; died Oct. 14, 1965, from pulmonary emphysema, aged 68.

Ritchie, John Andrews, Jacksonville; born in Yonkers, N.Y., Jan. 28, 1918; Duke University School of Medicine, Durham, N.C., 1943; interned at the U. S. Naval Hospital, Great Lakes, Ill., and served residencies in neuropsychiatry at Duke University Hospital, 1947-1949, and Fairfield State Hospital, Newtown, Conn., 1949-1950; practiced neuropsychiatry in Greenville, S. C., 1950-1954, and Durham, N.C. 1954-1958; began the practice of his specialty in Jacksonville in 1958; was a Navy veteran of World War II, serving as a submarine surgeon with the Submarine Force, Pacific Fleet; held membership in the American Medical Association, Southern Psychiatric Association, American Psychiatric Association, American Academy of Psychotherapy, Florida Psychiatric Society, and Northeast Florida Psychiatric Society of which he was a former secretary-treasurer; died February 3, aged 48.

Roberts, Tenney Hugh, Lakeland; born in Gray, Ga., Aug. 24, 1899; Medical College of Georgia, 1925; interned at the Emma Moss Booth Hospital and later continued graduate study at Cook County Graduate School of Medicine, Chicago; entered the private practice of medicine in Lakeland in 1925; was a staff member of Lakeland General Hospital for 40 years and president

of the staff in 1940; was president of the Polk County Medical Association in 1945; was a former councilor of the Florida Association of Industrial Surgeons; for many years was chairman for Polk County of the Florida Medical Association's Committee on Procurement and Assignment; was a veteran of World War I; held membership in the American Medical Association and the Southern Medical Association; died Oct. 15, 1965, aged 66.

Shisler, John W., Miami; born in Richwood, Ohio, March 4, 1887; University of Colorado School of Medicine, Denver, 1913; served an internship in Tacoma, Wash., 1913-1914; was vice president of the Dade County Medical Association in 1918 and from 1928 to 1933 was chairman of its health committee; was city health officer of Miami in 1919 and 1931-1933; was Miami's welfare director, 1928-1933; engaged in the general practice of medicine in Miami from 1914 until he retired in 1955; was a life member of the Florida Medical Association and the American Medical Association; died March 11, aged 79.

Sporn, Hymán, Hollywood; born Jan. 28, 1904; State University of New York Medical Center, Brooklyn, N. Y., 1926; served a two year internship at Beth Moses Hospital, Brooklyn, and studied in foreign clinics, 1929-1932; practiced his specialty of otolaryngology in Brooklyn for 30 years and in Hollywood for the last eight years; was a veteran of World War II, serving as a major in the Army Medical Corps from 1942 to 1946; was a member of the American Medical Association, American Board of Otolaryngology and American Academy of Ophthalmology and Otolaryngology and was a fellow of the American Society of Ophthalmologic and Otolaryngologic Allergy, International College of Surgeons, and American Otorhinological Society for Plastic Surgery; died February 3, aged 62.

VanNest, William Arnold, New Smyrna Beach; born in Monroe County, Michigan, 1924; Stritch School of Medicine of Loyola University, Chicago, Ill., 1936; came to Florida from Ashley, Ind., in 1946; had engaged in the general practice of medicine in New Smyrna Beach since that time; died January 20, aged 62.

WHAT'S THE
COMMON
DENOMINATOR? ...IRON



In fact, there's as much iron...250 mg.
...in a 5 cc. ampul of Imferon (iron dextran injection) as in a pint of whole blood.
When iron deficient patients are intolerant of oral iron...or orally administered iron proves ineffective or impractical...or if the patient cannot be relied upon to take oral iron as prescribed, Imferon (iron dextran injection) dependably increases hemoglobin and rapidly replenishes iron reserves.

IMFERON® (iron dextran injection)

IN BRIEF: ACTION AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion as a *source of iron*; infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb/100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. Initial test doses are advisable. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylatoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses. Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201



PRODUCTS
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EVERY DAY

**brings
peace to the
hyperactive
colon**



CANTIL[®] (mepenzolate bromide)

helps restore normal motility and tone

"In 40 of 44 cases of irritable or spastic colon, Cantil [mepenzolate bromide] or Cantil with Phenobarbital reduced or abolished abdominal pain, diarrhea and distention and promoted restoration of normal bowel function... Cantil [mepenzolate bromide] proved to be singularly free of anticholinergic side-effects... Urinary retention, noted in two cases was eliminated in one by reducing dosage."¹

IN BRIEF: One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

Supplied: CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

¹. Riese, J. A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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Milwaukee, Wisconsin 53201



**PRODUCTS
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DACTILASE®

Each tablet contains:

Dactil® (piperidolate hydrochloride), 50 mg.;
Standardized cellulolytic* enzyme, 2 mg.;
Standardized amylolytic enzyme, 15 mg.;
Standardized proteolytic enzyme, 10 mg.;
Pancreatin 3X** (source of lipolytic activity),
100 mg.; Taurocholic acid, 15 mg.

*Need in human nutrition not established.

**As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.

WHEN
STOMACHS
ARE ALL
BUTTERFLIES

AND
GAS



In chronic or acute indigestion, fluttery, gassy stomachs obtain prompt, gratifying relief through the antispasmodic, surface anesthetic and enzymatic activity of Dactilase. Dactilase decreases hypermotility and pain and reduces the production of gas. Dactilase does not induce stasis, but helps restore normal tone. It has little or no effect on enzyme secretions, but *adds* enzymes, thus contributing to the digestive efficiency of the patient.

Side Effects and Contraindications:

Dactilase is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

Administration and Dosage: One tablet with, or immediately following, each meal. Tablets should be swallowed whole.

Supplied: Bottles of 60 and 250.

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**WARMTH
FOR COLD
HANDS AND FEET**



For cold hands and feet, nothing beats hot stoves—but they *are* awkward to carry around. Now Gerilid, in good-tasting take-along chewable tablets can provide rapid vasodilation of peripheral circulation, bringing real warmth to the extremities and decreasing sensitivity to sudden temperature change. Patients *like* Gerilid and *know* they are getting relief.

GERILID™

Each chewable tablet contains:
nicotinic acid (niacin) 75 mg. and
aminoacetic acid (glycine) 750 mg.

Administration and Dosage: One or two chewable tablets 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation. The recommended dosage should not be exceeded.

Side effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is a concomitant administration of a coronary vasodilator.

Supplied: Packages of 50 chewable tablets.

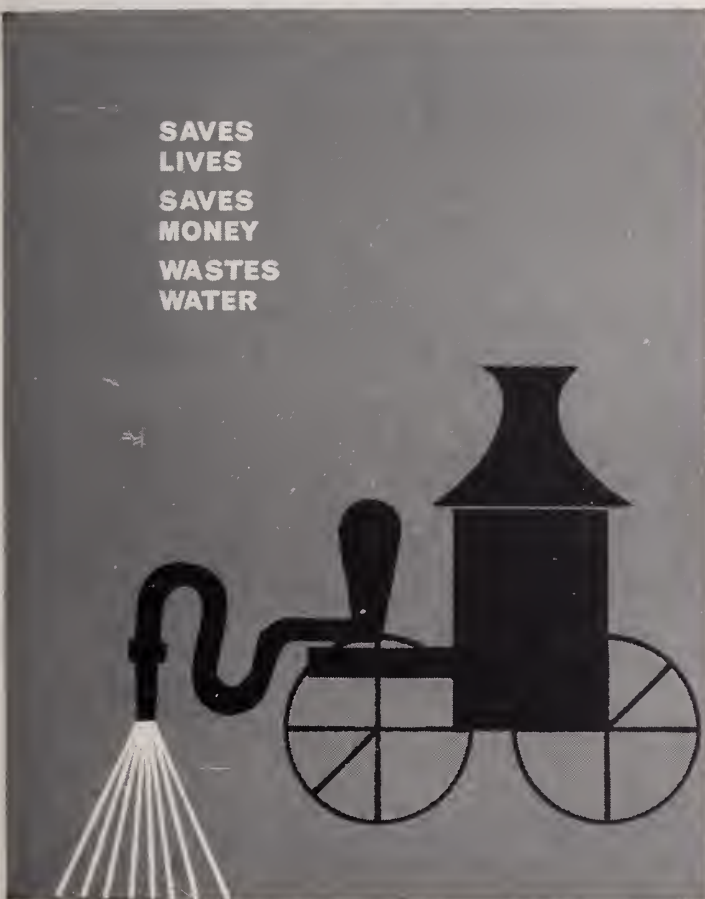
Also available in liquid form as Geriliquid®, in bottles of 8 and 16 ounces.

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**SAVES
LIVES
SAVES
MONEY
WASTES
WATER**



METAHYDRIN (trichlormethiazide) is prescribed by physicians because it not only approximates the diuretic efficacy of parenteral meralluride injection . . . but, *it is the least expensive of all "brand-name" thiazides.* Therefore, when you prescribe METAHYDRIN (trichlormethiazide) your patients receive the thiazide diuretic that removes a little more salt and water than earlier thiazides, with relatively less loss of potassium . . . and, it's therapy they can more easily afford . . . *only pennies a day.*

METAHYDRIN®

(trichlormethiazide)

oral diuretic

Dosage: One 2 or 4 mg. tablet once or twice daily.

Precautions: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

Side Effects: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have occasionally been noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by the administration of thiazides.

Contraindications: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

How Supplied: Bottles of 100 and 1000 tablets.

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**BRING IT DOWN
AND
KEEP IT DOWN**

190
102

Metatensin lowers blood pressure and keeps it low—effectively and economically. It combines reserpine with trichlormethiazide which affords more potent saluresis with less loss of potassium than from earlier thiazides. Reserpine contributes antihypertensive effect by relieving anxiety and tension. Metatensin is well-tolerated over long periods; with its effectiveness and economy it assures antihypertensive therapy you and your patients can stay with.

METATENSIN®

Each scored tablet contains:
METAHYDRIN® (trichlormethiazide)
2 mg. or 4 mg. and
Reserpine 0.1 mg.

Usual adult dose: One tablet twice daily. **Precautions and side effects:** Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery.

Contraindications: Complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.

Supplied: Metatensin tablets, 2 mg., 4 mg.—bottles of 100 and 1000.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 532



**PRODUCTS
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When depressed patients say:



"I can't sleep at night"



"I'm tired all day long"

NORPRAMIN[®]

(desipramine hydrochloride)

non-sedating • rapid-acting
ANTIDEPRESSANT

restores normal patterns of sleep and activity

Norpramin (desipramine hydrochloride) reverses the signs and symptoms of depression including sleep disturbances, feeling of sadness, guilt, worthlessness, anxiety and bodily complaints without physical basis. In 2-5 days most patients become more hopeful, more active and less weighed down by their problems.

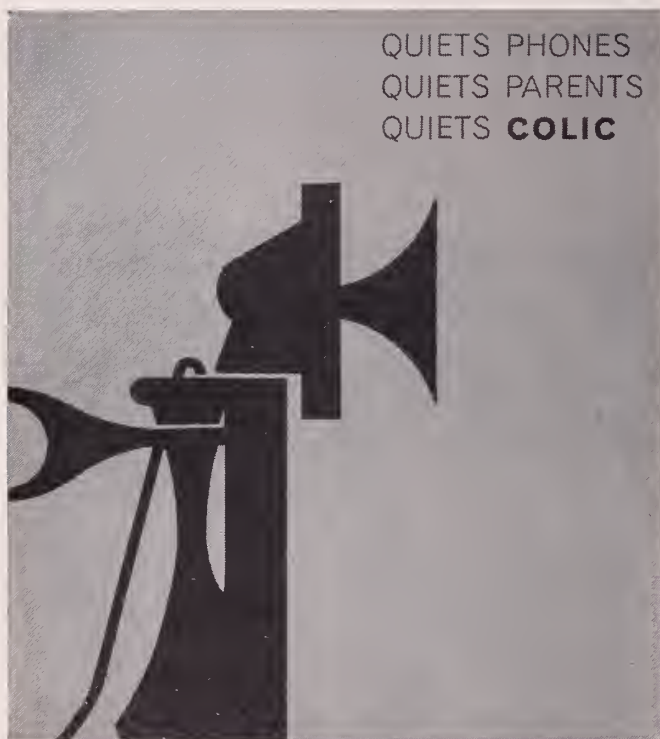
Norpramin (desipramine hydrochloride) has only slight sedative qualities, nevertheless sleep disturbances and restlessness are relieved as depression is lifted. If anxiety or tension develop or persist a tranquilizer may be added or dosage reduced. Side effects are usually mild, occurring in about 1 of 4 patients.

Indications: In moderate to severe depression—neurotic or psychotic. **Dosage:** Optimal results are obtained at a dosage of two 25 mg. tablets t.i.d. (150 mg./day). **Contraindications and Precautions:** Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease and epilepsy. Should not be given within two weeks of an MAO inhibitor. Safety in human pregnancy has not been established. **Adverse Effects:** Usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste", sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs. **Supplied:** Norpramin (desipramine hydrochloride) tablets of 25 mg., in bottles of 50, 500 and 1000.

PRODUCTS FOR PATIENTS YOU SEE EVERY DAY



LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201



QUIETS PHONES
QUIETS PARENTS
QUIETS **COLIC**

In colicky infants Pediatric Piptal with Phenobarbital slows down spasm, diminishes pain and crying and improves feeding patterns. It permits sleep and rest for patient and family. The less than hypnotic amount of phenobarbital in the recommended dose affords a mild, calming action and enhances the antispasmodic action of Piptal (pipenzolate bromide). The latter drug, as reported in the medical literature, has a favorable ratio of effectiveness to side-effects which is unusual in anticholinergics and thus is particularly appropriate to pediatric use.

PEDIATRIC PIPTAL® WITH PHENOBARBITAL

each cc. contains 6 mg. phenobarbital (warning: may be habit forming); 4 mg. Piptal® (pipenzolate bromide), and 20% alcohol.

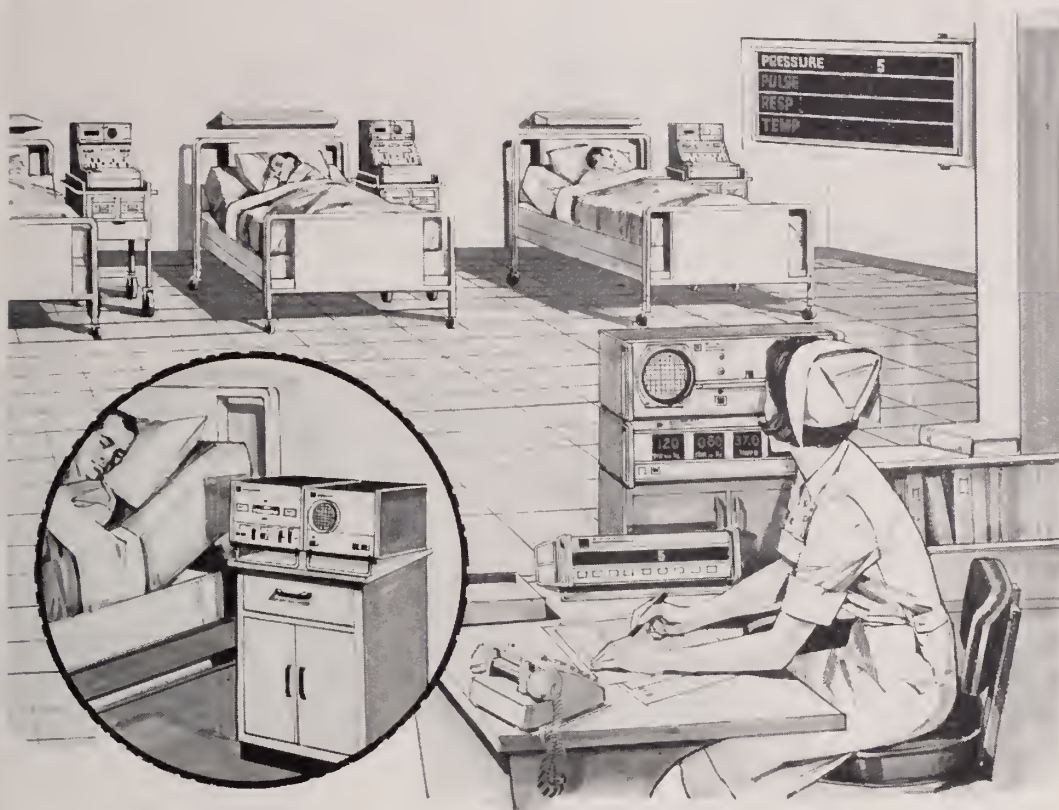
Pleasant-tasting Pediatric Piptal with Phenobarbital is miscible in milk, formulas and fruit juices, and may also be given by dropper directly on the infant's tongue. Dosage is 0.5 cc. 15 minutes before feeding; in severe cases, 1.0 cc. four times daily. High doses may occasionally cause constipation with tenesmus and, rarely, flushing without fever. It is contraindicated in bowel obstruction or sensitivity to phenobarbital or anticholinergics. Available in 30 cc. dropper bottles, droppers calibrated to deliver 0.5 cc.

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START SMALL **AND GROW**

*Sanborn's new Patient Monitoring Modules
adapt perfectly to expanding intensive-care needs*


Sanborn "Series 780" Patient Monitoring Systems alert the intensive-care staff *instantly* to the distress of any monitored patient, permitting more effective care of *all* patients by the available nurses.

Design of the systems in functional modules offers greatest flexibility in adapting any monitoring system to future needs — the hospital system can begin modestly and grow steadily, with original modules fully utilized in the expanding system. Also, monitoring capabilities can be quickly shifted from bed to bed, as needed. Separate modules for heart rate (with integral pacer if desired), for temperature and respiration rate, and for systolic and diastolic pressures. Other modules for synchronized defibrillation, for resuscitative cardiac pacing, for oscilloscope display of cardiac or pulse

waveforms, and for automatic pacing and ECG recording with any cardiac distress. Series 780 also includes remote alarm indicators (specific-parameter or general alarms, by bed) and remote patient-select push-button switchboxes for through-switching of patient signals to numerical display, oscilloscope, and/or chart recorders at the central station.

A complete range of transducers, recorders, and data displays engineered by Sanborn allows us to design, install, and fully warrant the complete system required for unexcelled patient care in your hospital.

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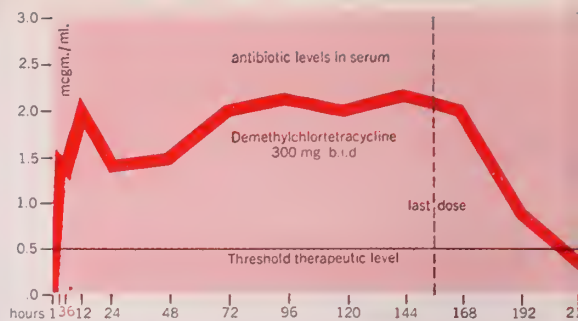
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greater potency

lower mg intake per day

600 mg versus 1,000 mg

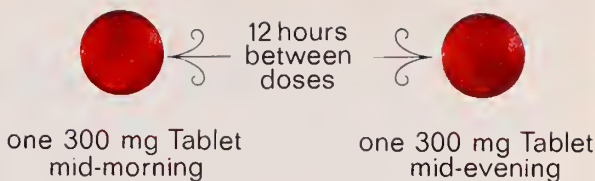
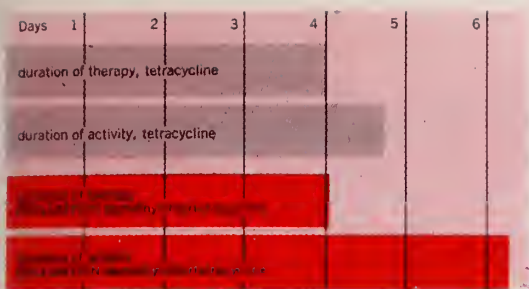


higher activity

levels than ordinary tetracyclines

From Sweeney, W. M., Dornbush, A. C., and Hardy, S. M.;
Amer. J. Med. Sci. 243:296 (Mar.) 1962





1-2 days' "extra" activity
after the last dose to protect against relapse

It's made for b.i.d.

in G.U. infections
broad-spectrum performance
above and beyond the activity of
ordinary tetracyclines

DECLOMYCIN[®]

DEMETHYLCHLORTETRACYCLINE

Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive.

Contraindication—History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of discomfort.

Precautions and Side Effects—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should

be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

Capsules: 150 mg; *Tablets:* film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

Schedule of Meetings

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	George S. Palmer, Tallahassee.....	Floyd K. Hurt, Jacksonville	Bal Harbour, May 11-12
Florida Specialty Societies			
Allergy Society	Woods A. Howard, Lakeland	Richard C. Hartsfield, J'ville	
Anesthesiologists, Soc. of.....	J. Gerard Converse, Jacksonville	Howard M. DuBose, Lakeland	
Chest Phys., Am. Coll. Fla. Chap.	Franklin G. Norris, Orlando	William W. Bruce, Winter Park	
Dermatology, Soc. of	Arthur Appleyard Jr., St. P'burg	William P. Clarke, Jacksonville	
General Practice, Academy	Walter W. Sackett Jr., Miami	E. Charlton Prather, Orange Park	
Health Officers, Soc. of	Joseph W. Lawrence, Ft. Myers	Abbott V. Wilcox Jr., St. P'burg	
Internal Medicine	Addison L. Messer, St. P'burg	Jack W. Barrett, Miami	
Neurosurgical Society	James F. Cooney, W. Palm Beach	Joseph W. Pilkington, St. P'burg	
Obst. & Gynec. Society	William T. Mixson Jr., Coral Gbls.	Charles F. McCrory, Jacksonville	
Ophthalmology Society	Younger A. Staton, W. Palm Beach	West Bitzer, Ocala	
Otolaryngology Society	M. A. Schofman, Miami	Robert J. Piaff, Lakeland	
Orthopedic Society	William J. Hutchison, Tallahassee	Marcus J. Zbar, Ft. Lauderdale	
Pathologists, Society of	Jerome Benson, Miami Beach	Richard G. Skinner Jr., J'ville	
Pediatric Society	Oliver F. Deen Jr., Tampa	Bruce B. Sutton, Coral Gables	
Phys. Med. & Rehab., Fla. Soc.	Sterling H. Huntington, Coral Gbls.	Robert L. Wells, St. Petersburg	
Plastic & Reconstr. Surg.	James G. Robertson, Miami	John T. McCormick, Jacksonville	
Proctologic Society	John J. Cheleden, Daytona Beach	Moke W. Williams, Ft. Lauderdale	
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Urological Society	Robert N. Webster, Tallahassee		

(Most Specialty Group meetings are scheduled at the time of the annual meeting of the Association)

FLORIDA

American Cancer Society, Div.	Sam W. Denham, Jacksonville	Mrs. Martin Gould, Ft. Pierce	Sarasota, October 1966
Arthritis Foundation, Chap.	Ernest R. Currie, Daytona Beach	Barbara White, Gainesville	Jacksonville, May 1967
Basic Science Examining Board	Paul A. Vestal, Winter Park	Theodore A. Ashford, Ph.D., 1832 Bearss Ave., Tampa 33612	Tampa, Nov. 5, '66
Blood Banks, Association	Alfred L. Lewis Jr., Tallahassee	Dorothy C. Smith, J'ville	Sarasota, 1967
Blue Shield of Florida, Inc.	W. Dean Steward, Orlando	John T. Stage, Jacksonville	Bal Harbour, May 11
Crippled Children & Adults, Soc. of	Bruce Thomason, Gainesville	Mrs. Page Hufty, Palm Beach	Orlando, Dec. 2-3, '66
Diabetes Association	Seymour L. Alterman, Miami Bch.	Robert T. Rengarts, Sebring	Miami, Sept. 29-30, '66
Heart Association	Donald E. Warren, W. Palm Beach	Philip F. Ashler, Pensacola	Jacksonville, May 1966
Medical Examining Board	J. Champneys Taylor, J'ville	Leo Grossman, M.D., P.O. Box 5 Biscayne Annex, Miami 33152	Miami Beach, July 1
Mental Health, Association for	Mrs. Richard F. Stover, Miami	Mrs. Alfred Koenig, St. Petersburg	Ft. Lauderdale, Apr. 2
National Foundation	Basil O'Connor, New York City	Ed Foreman, Orlando	Washington, D. C., O
Nat'l Multiple Sclerosis Soc.	Harold W. Comfort, New York	Robert E. McWeeney, Hollywood	November 1966
Prevention of Blindness, Soc. for	Mrs. S. R. Kirby, St. Petersburg	Mrs. Richard Nosti, Tampa	Hollywood, Sept. 28-30
Public Health Association	William R. Stinger, Miami	Mrs. J. M. Riedel, Cocoa	Ft. Lauderdale, May
Retarded Children, Association for	Mrs. G. F. Ward, Avon Park	T. S. Feng, W. Palm Beach	Hollywood, April 1966
Thoracic Society	L. H. Kingsbury, Orlando	J. C. Inman, Orlando	Orlando, Apr. 21-23,
Tuberculosis & Res. Dis. Assn.	Tom Coldevey, Port St. Joe	Harry Botwick, Miami	October 1966
United Cerebral Palsy of Florida	J. Thomas Gurney Jr., Orlando	Mrs. Linus W. Hewit, Tampa	Bal Harbour, May 11
Woman's Auxiliary	Mrs. Allen E. Kuester, Cocoa		
American Medical Association	Charles L. Hudson, Cleveland	F. J. L. Blasingame, Chicago	Atlantic City, June 18
A.M.A. Clinical Session			Las Vegas, Nov. 27-30



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Brevard	Adrian R. Jensen, Rockledge	Donald M. Bryan, Cocoa	1st Tues.	5	144
Broward	Ray E. Murphy Jr., Pompano Beach	Theodore W. Hahn, Pompano Beach	4th Tues.	44	369
Charlotte	Carl N. Reilly, Punta Gorda	Francis T. Zinn, Punta Gorda	2nd Tues.	0	11
Clay	William A. Mulford, Gr. Cove Spgs.	Aubrey Y. Covington, Gr. Cove Spgs.	3rd Wed.	0	10
Collier	Bruce Boynton II, Naples	Ethel H. Trygstad, Naples	3rd Wed.	1	18
Columbia	John T. Wilson, Lake City	Charles T. Ozaki, Lake City	3rd Wed.	0	15
Dade	William M. Straight, Miami	H. Clinton Davis, Miami	1st Tues.	200	1,310
DeSoto-Hardee-Glades	Gordon H. McSwain, Arcadia	Calvin W. Martin, Arcadia	1st Tues.	1	17
Duval	Wade S. Rizk, Jacksonville	Herbert A. Burke Jr., Jacksonville	1st Tues.	65	382
Escambia	Joseph Q. Perry, Pensacola	William R. Bell, Pensacola	2nd Tues.	2	133
Franklin-Gulf	Harold B. Canning, Wewahatchka	Photis J. Nichols, Apalachicola	Last Wed.	0	5
Gadsden-Liberty	Hilliard R. Reddick, Quincy	George H. Massey, Quincy	Quarterly	0	15
Highlands	Donald C. Hartwell, Avon Park	Walter M. Ost, Avon Park	3rd Mon.	2	23
Hillsborough	James A. Winslow Jr., Tampa	Frank A. Massari, Tampa	1st Tues.	7	324
Indian River	William R. White, Vero Beach	Hampton L. Schofield Jr., Vero Beach	2nd Tues.	0	23
Jackson-Calhoun	Glenn E. Padgett, Marianna	Francis M. Watson, Marianna	Quarterly	0	18
Lake	Geoffrey H. Binneveld, Leesburg	C. Robert Crow, Mt. Dora	1st Mon.	2	43
Lee-Hendry	Charles C. Donegan Jr., Ft. Myers	Edward W. Salko, Ft. Myers	3rd Mon.	4	70
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Manatee	Marvin Silver, Bradenton	James R. Kennedy, Bradenton	2nd Tues.	4	58
Marion	Robert L. Gibson, Ocala	West Bitzer, Ocala	3rd Tues.	6	44
*Levy					
Monroe	Herman K. Moore, Key West	Jose T. Sanchez Jr., Key West	1st Thurs.	2	21
Nassau	Cecil B. Brewton, Fernandina Beach	John B. Britton, Fernandina Beach	2nd Thurs.	4	8
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Okaloosa	Henry I. Langston, Ft. Walton Beach	Frederick F. Crews, Ft. Walton Beach	1st Wed.	0	23
Orange	Harold W. Johnston, Orlando	Duane C. Deen, Orlando	3rd Wed.	46	313
*Osceola					
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Putnam	James C. Kitaf, Palatka	James R. Sayers, Palatka	2nd Tues.	1	14
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Santa Rosa	Elbert W. Sutton, Milton	Claude J. Barnes, Milton	5	12	
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Seminole	Robert J. Smith, Sanford	John T. Johnson, Sanford	2nd Tues.	0	26
Suwannee-Hamilton-Lafayette	Frederick T. Mickler Jr., Jasper	James F. Dietrich, Live Oak	1st Sat.	0	7
Taylor	James A. Rawls Jr., Perry	John A. Dyal Jr., Perry	Last Fri.	0	7
*Dixie					
Volusia	Michael R. Blais, Daytona Beach	Thomas D. Cook, Daytona Beach	2nd Tues.	7	122
*Flagler					
Walton	Howard F. Currie, DeFuniak Springs	McKinley Cheshire Jr., DeFuniak Spgs	3rd Tues.	0	7
Washington-Holmes	John T. Grace, Bonifay	James B. Craven, Chipley	Quarterly	0	5
Total				575	4,891
Grand Total					5,466

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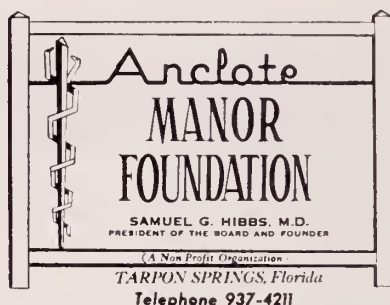


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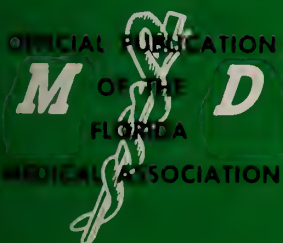
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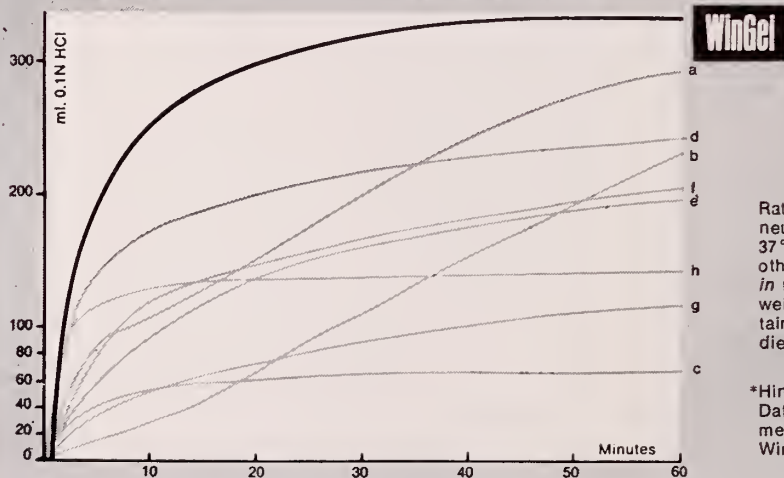
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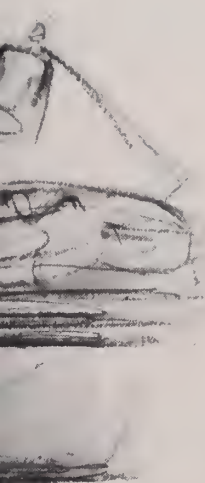
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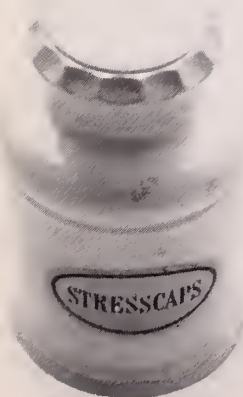
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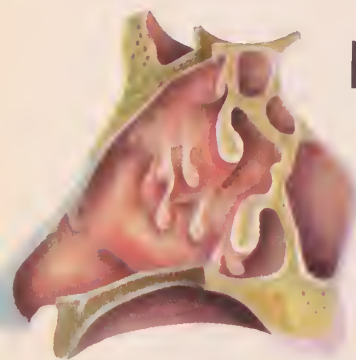


this issue: emergency anesthesia and the common cold

When emergency anesthesia is complicated by the common cold

Barry Belonsky, M.D., F.A.C.A.

Staff Anesthesiologist, Hospital of The Albert Einstein College of Medicine, New York City



Medical facilities are often presented with unfamiliar patients who have unknown health histories. This is particularly true in emergency situations that arise due to accidents or acute illnesses. These cases may need prompt care re-

quiring anesthesia, and if they involve colds, nasal allergies or other upper respiratory infections, can account for many complications which make up a major hazard during emergency anesthesia.

Administration of general anesthesia to a patient with a cold or upper respiratory infection is a hazardous undertaking. It should be avoided if at all possible. Indeed, the presence of U.R.I. is good reason for postponement of elective surgery.¹ In emergency surgery, regional or local block should be considered, but if general anesthesia is mandatory, it should be approached with utmost caution.

Since the attitude of "emergency surgery — hurry" has been replaced by "emergency surgery — watch out";² a knowledge of the complications is a great help in preventing them. Here is a brief outline of the problems involved and their treatment. Prevention of the complications is discussed later.

Complications during the induction of anesthesia

Most of the complications are a direct result of secretions and some a result of accompanying secondary infection. For example, *airway obstruction* due to excessive secretions occurs very commonly and is the direct effect of the cold. Respiratory exchange may be obstructed at any time during anesthesia because of excessive secretions, but is most likely to occur during induction. Suction apparatus must be available to overcome this.³

Excess secretions which stimulate and irritate the epiglottis and vocal chords can cause *laryngeal stridor and obstruction*. This can lead to complete laryngeal closure with resultant anoxia and death.

Bronchospasm and laryngospasm can result from secretions penetrating the bronchi and bronchioles. In laryngospasm, there are both inspiratory and expiratory stridor and difficulty in inflating the chest. In bronchospasm there is an expiratory wheeze, but not as much difficulty in inflation, although some resistance may be felt. Stridor is due to partial or complete closure of the vocal cords in spasm and the "crowing" sound is almost pathognomonic.

Secretions obstruct the nasal airways. This produces *difficulty in ventilation* through the mouth until the patient is deep enough to place an oral airway. An intravenous agent can be given to facilitate the induction of anesthesia.

Difficulties can arise if intubation is performed to ventilate the patient. For example, teeth can be broken by too vigorous attempts at intubation, or the intubation itself may be technically difficult due to secretions obstructing the view of the glottis. The postoperative sequelae of intubation ranges from mild laryngitis to pneumonia with atelectasis, and are seen far more commonly in patients suffering from colds than in normal patients.



Successive stages of laryngospasm which produce the characteristic stridor or "crowing" sound.



Progression of
bronchioles into bronchospasm.

Complications during the maintenance of anesthesia *Bronchospasm* can occur in an un-
tubated patient due to secretions entering the bron-
chial tree from above, and acting as an irritant to
the bronchi and bronchioles. Secretions accumulate
quickly and the patient has to be suctioned continu-
ously. The whole cycle of coughing, bucking, laryngo-
spasm and bronchospasm may ensue. The difficult
decision here is whether it is better to suction the
patient continually or to use an endotracheal tube
which protects the cords and bronchi but introduces
the risk of attendant complications.

Postoperative complications Postoperatively,
complications can be more serious than even the intra-
anesthesia complications, and occur much more fre-
quently in a patient who has been intubated.⁴

Sore throat and pharyngitis can result both from the
preoperative upper respiratory infection and from
the drying of the mucous membranes which occurs
during anesthesia.

Tracheitis and bronchitis often result from secre-
tions trickling down the tracheobronchial tree.

Laryngitis is frequently seen in patients with upper
respiratory infections who have been intubated.
There is a significant increase in the incidence of
laryngitis compared to that in patients without up-
per respiratory infections.

Subglottic edema is a condition which occurs mainly
in children who have been intubated. This pathol-
ogy results from an exudate developing in the areo-
lar tissue just below the cords. Because of the small
size of the child's trachea, even a 1 mm increase in

size of the mucous membrane can severely impair
the air passage. Children exhibit this by severe ex-
piratory stridor and may even become cyanotic. This
may so severely embarrass the child's breathing that
it must be treated vigorously. Most authorities agree
on the treatment^{5,6,7,8} consisting of a high oxygen
concentration in the inspired air (60%), plus high
humidity (close to 100%). Adequate parenteral
fluid intake and slight cooling of the body tempera-
ture (by a cooled oxygen tent) also help in mild cases.
In severe cases, there may be hypoxia which in-
creases the restlessness and the oxygen demand rises.
Sedation is often necessary, although concomitant
depression of the respiratory center is undesirable.
An antihistaminic accomplishes this purpose well,
and adds sedation. Since there is always a possibility
that an allergic response plays a role in edema, some
relief of the respiratory distress may occur. Steroids
should be used to control inflammatory and allergic
phenomena and swelling. If all this fails, and the
patient is still restless and hypoxic, a tracheostomy
should be performed immediately.

(concluded on following page)



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Cross section of trachea showing subglottic edema and lumen reduction due to mucous membrane congestion.

Pneumonia may also follow anesthesia administered to a patient with a cold. This can be caused by accumulated secretions becoming secondarily infected and causing consolidation of the lung. *Atelectasis* of the lung can result if one of the bronchioles becomes plugged by secretions, preventing aeration of the distal part of that lung. This is seen more frequently following upper respiratory infection because dry anesthetic gases aggravate the infection, causing secretions to change from watery to thick and viscid, and consequently difficult to suction.

Prevention of complications The first rule to prevent complications, of course, is to use a regional or local anesthesia whenever possible. But when emergency surgery is a must, in spite of the presence of a cold, allergy, or upper respiratory infection, here are some ways to prevent complications.

Give nose drops preoperatively. This can help shrink the congested nasal mucous membranes and reduce secretions for better air passage. (Results of this method are sometimes unsatisfactory because of the short duration of effect or rebound congestion.) For longer effect, oral antihistamines with nasal decongestants are often given to provide and maintain a drying effect on secretions.

To clear the tracheobronchial tree, instruct the patient to cough preoperatively. Cold steam or water nebulizers effectively humidify the nasal, pharyngeal and bronchial passages and often make the patient more comfortable. Tenacious secretions be-

come more watery under humidification, clear more thoroughly preoperatively and are more easily suctioned from the airway during anesthesia.

Give intravenous fluids to those patients who appear dehydrated due to a cold. In a well hydrated patient the respiratory tract secretions are less viscid and more watery. This is particularly true in asthmatic

Summary: Administration of emergency anesthesia to a patient with a cold or upper respiratory infection can lead to a chain of events that may result in increased postoperative morbidity and even death. This is because of the excess secretions formed in these conditions. Preoperative measures to prevent or reduce these secretions should be undertaken and will result in smoother and safer anesthesia.

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Tablet daily
brings pressure down

Advantage: Both components of Regroton
are long-acting.

Average dosage: One tablet daily with
breakfast.

Contraindications: History of mental
depression, hypersensitivity, and most
cases of severe renal or hepatic diseases.

Warning: Discontinue 2 weeks before
general anesthesia, 1 week before electro-
shock therapy, and if depression or
peptic ulcer occurs. With administration
of enteric-coated potassium supplements,
the possibility of small bowel lesions
should be kept in mind.

Precautions: Reduce dosage of con-
comitant antihypertensive agents by one-
half. Discontinue if the BUN rises or
renal dysfunction is aggravated. Electro-
lyte imbalance and potassium depletion
may occur; take particular care in
patients with severe ischemic heart disease,
and in patients receiving corticosteroids,
TH, or digitalis. Salt restriction is not
recommended. Use with caution in
patients with ulcerative colitis, gall-
stones, or bronchial asthma.

Side effects: Nausea, vomiting, diarrhea,
muscle cramps, headaches and dizziness.
Occasional side effects include angina pecto-
ris, anxiety, depression, drowsiness,
hyperglycemia, hyperuricemia, lassitude,
leukopenia, nasal stuffiness, nightmare,
pruritus, urticaria, and weakness.

For full details, see the complete prescrib-
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Availability: Bottles of 100 and 1000 tablets.

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(plus all the advantages of
tetracycline phosphate complex)

new Tetrex bidCAPS^{TM*}

(tetracycline phosphate complex)

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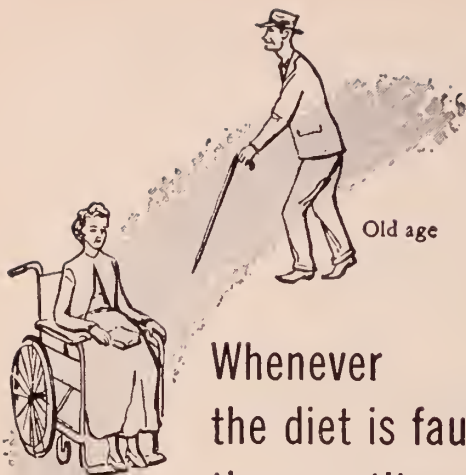
BRISTOL

BRISTOL LABORATORIES
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BRISTOL THERAPEUTIC SUMMARY: For complete information consult Official Package Circular. **Indications:** Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms. **Contraindications:** The drug is contraindicated in individuals hypersensitive to tetracycline. **Warnings:** Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. No cases of photosensitivity have been reported with tetracycline phosphate complex. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). **Precautions:** Mycotic or bacterial superinfection may occur. Infants may develop increased intracranial pressure with bulging fontanelles. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. **Adverse Reactions:** Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis and allergic reactions may occur. **Usual Adult Dose:** 500 mg. b.i.d. Continue therapy for 10 days in beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals.

References: 1. Roberts, C. E., Jr.; Perry, D. M.; Kohn, H. A., and Kirby, W. M. M.: A. M. A. Arch. Int. Med. 107:204 (Feb.) 1961.

bidCAP contains Tetrex (tetracycline phosphate complex equivalent to 500 mg. tetracycline HCl activity).



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Adolescence



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stimulates the appetite,
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Contraindications: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised; especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of pre-existing symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dose—operation of motor vehicles, machinery or other activity requiring alertness should be avoided. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia, the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor, and respiratory collapse.



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button popper**



**Second aid for a
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Indications: Meprobamate is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, meprobamate fosters normal sleep through both its anti-anxiety and muscle-relaxant properties.

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Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdrawal gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses.

Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

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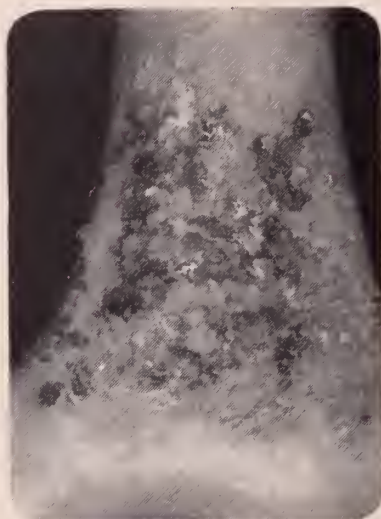
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After treatment —
with ARISTOCORT Topical
Ointment 0.1% for two weeks

ARISTOCORT® Triamcinolone Acetonide Topicals have proved exceptionally effective in the control of various forms of eczema: allergic, atopic, nummular, psoriatic, and mycotic.

In most cases responsive to topical ARISTOCORT, the 0.1% concentration is sufficiently potent. The 0.5% concentration provides enhanced topical activity for patients requiring additional potency for proper relief.

Administration and Dosage: Apply sparingly to the affected area 3 or 4 times daily. Some cases of psoriasis may be more effectively treated if the 0.1% Cream or Ointment is applied under an occlusive dressing.

Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side

effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive non-permeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyoderma will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

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Pulvule®	Enseal® (enteric-release tablet, Lilly)	Capsule-Shaped Tablet	Elliptical Tablet	Round Tablet





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could save
your patient's
life**

(see previous page)

The JOURNAL

of the Florida Medical Association

To See Ahead . . .

It is said that looking backward from time to time improves one's ability to see ahead. Although this is the practical view of history, it must also be recognized that stories of bygone persons and places frequently make fascinating reading in themselves.

In this second special medical historical issue, *The Journal* hopes to fulfill both functions.

In our initial historical effort of July 1965, a variety of original material was included. The issue received many favorable comments.

The 1966 historical issue, while containing a lesser number of articles, will probably be more varied than its predecessor.

Chronologically, a considerable span of time is involved, ranging over the centuries from the momentous voyage of Christopher Columbus all the way to the illustrious present day Palmer family of physicians.

Readers should find much of interest in the saga of the remarkable and versatile Odet Philippe, as chronicled by Dr. William M. Straight. He takes us from the subject's birthplace in Europe to that early seat of New World culture, trade and medical knowledge, Charleston, South Carolina, later to what is now Fort Lauderdale, then to Key West, and finally to his last home and resting place, the Tampa Bay area. Dr. James M. Ingram has provided us a remarkable description of former days in that same area with his excellent article on Dr. John P. Wall, the crusading tenth president of the Florida Medical Association.

Florida's medical Palmer family and its great tradition of physicians, having given us three

FMA presidents, is ably presented by two members of the family.

A vivid picture of appalling public health problems in Jacksonville during the early days of the century and how they were solved by the area's unsung and underpaid first health officer has been furnished by Dr. Edward R. Smith.

Last, but by no means least, Dr. Clifford C. Snyder allows us to accompany the little known medical men who made the "Great Voyage" with Columbus. He brings out many new and thought-provoking questions and facets about one of the world's highest adventures, which culminated on islands only a short distance off Florida's shores.

The *Journal* is deeply indebted to all of the authors who gave so much time to share their interests and labors with their colleagues through our pages. Special gratitude must be expressed to Dr. Straight, who assumed, as chairman of the Association's Committee on Archives, responsibility for locating, encouraging, coordinating and even editing much of the material in the issue. Somehow he found time to do all of it in addition to his many other duties, not the least of which is his current presidency of our largest county organization, the 1,500 member Dade County Medical Association.

It is the hope of *The Journal* that such activity will stimulate more of its readers to become writers. In perusing this issue, we hope they will obtain not only an appreciation of events past, but a clearer view of the paths ahead.

T.M.

Odet Philippe

Friend of Napoleon, Naval Surgeon

And Pinellas Pioneer

WILLIAM M. STRAIGHT, M.D.*

Folks in Miami remember the storm of '26, those on the Florida Keys the '35, but those over on the Pinellas peninsula talk about the hurricane of '48: September 23-25, 1848, that is. For about three days the wind increased steadily in velocity and the old timers remarked that Old Tampa Bay had seemed to almost go dry; the water had receded to the channel. Trees had been uprooted and their tops broken out by the steady, twisting force of the wind. Then suddenly the wind layed and everything became dead calm. Out of this eerie stillness, off in the distance could be heard a steadily increasing roar. Dr. Odet Philippe, standing on the porch of his house on the low shore line just east of a fifty foot Indian mound near the head waters of Old Tampa Bay, saw a huge wall of water moving up the bay with a thunderous roar. He turned and shouted to his wife and servants to bring the children and climb the Indian mound at once. Barely moments ahead of the surging wall of water they reached the top of the mound. In wide-eyed astonishment they watched as their house was ripped apart by the raging waters that even tore into the centuries-old Timucan shell mound. Hours later when the storm had abated and the waters receded, they climbed down the mound to view the battered wreckage. A five year old girl among those atop the mound told her niece, Gladys Booth Tucker, of the many bolts of gay-colored cloth washed from the house which festooned the trees in all directions.¹ Dr. Philippe, not to be discouraged by such a tragedy, salvaged lumber from the wreckage and what furnishings he could. With these he rebuilt his house on a hill just behind the mound that had saved their lives.

Dr. Odet Philippe, also known as Count Ode Philippe (Phillippe, Phillippi) was the first settle on the Pinellas peninsula, and was no stranger to tragedy. It is said he was born at Lyons France, about 1769; however, efforts to document his birth through the French Historical Archive have been unsuccessful. Story has it that he was the nephew of Louis, King of France (probably Louis XVI who was executed in 1793). He attended a fashionable boarding school in Lyon where a fellow student was Napoleon Bonaparte. Odet and Napoleon became firm friends and later both went to Paris, Napoleon to study military science and Odet Philippe to study medicine. Philippe is described as "a person of joyous buoyant spirit, noted for his frankness and rugged constitution; a brilliant student excelling in mathematics, geography, Latin, French and Spanish. He also distinguished himself as a promising artist, turning out student paintings, disclosing mature ability."²

Napoleon later appointed Philippe surgeon in the Royal Navy, and acting in this capacity Philippe was captured at the Battle of Trafalgar October 21, 1805. He was sent to England, prisoner of war, and "after months of being shut in the London jail, an offer was made for them to leave England in the middle of the night . . . otherwise they would be publicly executed. Philippe and a friend along with other refugees accepted the offer and made their way to the Bahamas. After a period of living in the Bahamas during which time he learned something of city culture and practiced medicine among the habitants and refugees, he made his way to Charleston, South Carolina, about 1808.

*Instructor in History of Medicine, Department of Medicine, University of Miami School of Medicine.

In Charleston he joined a large French colony and soon accumulated considerable wealth as a grower of cotton, corn and tobacco, a cigar maker (in 1819 and 1822 he is listed in the city directory as a "segar maker on East Bay Street"),⁴ and an owner of trading vessels. He had a town house in Charleston and a plantation "in near by Mount Pleasant, across the river from Charleston. . . ."⁵

There is no evidence that Philippe practiced medicine in Charleston. His name does not appear on the rolls of the Medical Society which are quite complete for this period. A careful search of the Charleston Courier for the years 1805, 1808, 1814 and 1825 revealed the names of many physicians but not his. He is listed on April 5, 1825 among those having letters to be picked up at the post office.

About 1808 he married a beautiful lady, Dorothee Desmottes, and by her had four daughters: Louise Poleanna, Elizabeth Octavie, Septima Marie, and Melanie (Millie or Merleyne). At the birth of Melanie tragedy struck again, for his wife died in childbirth. He obtained the services of a family friend, Marie Charlotte Florence Fontaine, to care for his little brood and later married this lady. She proved to be overly ambitious, a social climber, poorly suited to the rearing of children, and "a veritable volcano with her ungodly temper."⁶

Shortly after his marriage to his second wife he signed a note for a considerable sum of money to help the friend who had accompanied him from London. The friend defaulted on his note and left



Odet Philippe, Friend of Napoleon,
Naval Surgeon, and Pinellas Pioneer
1785 - 1869

town, forcing Philippe to pay it off. To meet this calamity Philippe had to sell his plantation and other possessions. He attempted a comeback briefly in the candy business but this proved a failure. Finally, disheartened, he assembled the remainder of his possessions, bought a sailing vessel, which he named "The Ney" after the famous marshal of Napoleon's army, loaded his possessions, family and remaining slaves, and set sail for Florida.



Philippe Homesite on the Shore of Old Tampa Bay

About January 1828, he put in at a fresh-water stream which is now known as New River, the site of the present Fort Lauderdale. Here he attempted to establish a salt industry. "His slaves scooped out great holes which were permitted to fill with sea water. After wind and sun had carried on evaporation to a certain point, the residue was dipped out and poured into big boilers—no doubt the kettles included in the ship's cargo. When this had been reduced to a solid, the top layer would be commercial salt, the second saltpeter, and the bottom alum."² This venture proved a failure because of the presence of so much alum and saltpeter and so little sodium chloride. He is also said to have made trips to the Bahamas to obtain seeds from which he grew citrus, mangoes, avocados and guavas along the Indian River. For several years he lived in peace with the Indians. His only neighbor was a Mr. Cooley who settled with his family about a mile away.

He may have maintained a residence in Key West during this period, for he appears as a resident on the census there and is said to have been in the cigar business there about 1834-1838.⁷ He appears to have practiced medicine in Key West. In one of his "Sketches of Florida" printed in the *Charleston Mercury* of July 12, 1833, Dr. Benjamine B. Strobel,⁸ resident of Key West from 1829 until 1833, reported a dialogue which allegedly took place between a physician and a "French quack." Strobel states, "When I arrived at the Key the principal practice was in the hands of a French quack, who, by trade, was a segar maker." Strobel goes on to tell us: "In addition to practicing medicine he kept a coffee room and a billiard table. I recollect seeing the following bill which he presented to a gentleman:

<i>Mr. Wilson</i>	<i>To</i>	<i>O. P. Q.</i>	<i>Dr.</i>
1829			
July 1,	To	1 cup Coffy	\$ 12.5
3,	To	1 Vomile	\$ 37.5
6,	To	4 Games Billiards	\$ 50
8,	To	1 Purgatif	\$ 25
			<hr/>
			\$1.25

In 1833 Odet Philippe was appointed Justice of the Peace of Monroe County by the Territorial Governor, and in February, 1836, was one of the signers of a petition protesting the formation of Dade County from Monroe County.

In 1835 the second Seminole War began. One sunny afternoon three friendly Indians visited Philippe at New River. They told him that he must flee for his life. When he asked how soon he must leave, they held up two fingers indicating he had two days. Hurriedly loading his family, slaves and possessions aboard *The Ney*, in early January, 1836, he weighed anchor and set sail for Key West. He stopped briefly near the mouth of the river to pick up his neighbor, Mr. Cooley, who had returned from a trip to find his wife, three children, and the children's tutor had been murdered by the rampaging Indians.

Following this Indian attack at New River some 200 settlers between New River and the lower Keys flocked into Key West for protection. Commodore Dallas in the United States Frigate *Constitution* was dispatched to Key West to protect the people.

Key West must have been to Philippe's liking. It was a city of 81 buildings about this time including two warehouses valued at \$6,000 each. The population numbered about 800 among whom were a number of highly intelligent and well educated people. Indeed, several of the leading citizens had migrated from Philippe's former home, Charleston, South Carolina. Social life consisted of learned discussions or card games often played far into the night. The ever present mosquitoes were thwarted by surrounding the table and players with a tent of mosquito netting. Then, too, the evening arrival of the biweekly mail packet from St. Marks spawned dinners of friends awaiting its arrival. The young bachelors such as Stephen R. Mallory, further enlivened the town at night by serenading the unwed ladies on the mandolin.

Business life consisted of cigar making, warehousing, salt making and the most lucrative of all wrecking. At this time twenty good-sized vessels were regularly engaged in wrecking.⁷ Key West however, was never to the liking of the doctor's society-minded wife. Philippe pacified her to some extent by taking her on trips to Havana. On December 10, 1846,⁹ his second wife, Mari

Charlotte Florence, threw a tantrum and died of a cerebral hemorrhage. She is buried in Key West.

Perhaps to escape the memories of his past disappointments or perhaps for business reasons he moved to Tampa where an old deed book records his purchase of three lots "on Tampa Street from Augustus Steele for one hundred dollars, on February 5, 1839."¹⁰

Fort Brooke, the nucleus around which the present city of Tampa grew, was established in 1823. During the Seminole War of 1835-1842 this "Fort" was the site of much activity. For the few civilians living around the "Fort" money could be made more easily than in Key West. Covington¹¹ tells of a grog shopkeeper who sold 200 barrels of whiskey to the soldiers in one year. Philippe may have arrived in time to profit from this "boom" for story has it that he had established businesses there as early as 1839. Judging from an existent account book¹² he was the owner of a bowling alley, he operated an oyster saloon, he dealt in real estate, mules, cattle and slaves, and was also a stockholder in the first hotel to be built in Tampa. This was a twelve room frame structure on the river front just north of the garrison. It is also said that he established a fishing industry which supplied fish for the soldiers at Fort Brooke.

Sometime before 1842 he homesteaded 160 acres of land near the head waters of Old Tampa Bay at the site that is now known as Philippe Park near Safety Harbor. He received a deed for this property (dated 1850) under the Armed Occupation Act of 1842. It is likely he learned of this beautiful spot from the soldiers who were stationed on the Pinellas peninsula during the Seminole War. There is, however, a delightful legend that in one of his many trips to the Bahamas to obtain plants for cultivation along the Indian River, his ship was intercepted by a pirate ship captained by a man named Gomez. On learning that Philippe was a physician, Gomez, who was ill, enlisted his services and Philippe succeeded in curing the old pirate. So grateful was the pirate that he gave Philippe and his family their freedom, a letter to protect them from further depredations by Gomez's followers, a cask of jewels, and a map on which he indicated the site on Old Tampa Bay.

Philippe named his estate St. Helena after the island on which his boyhood friend, Napoleon, was exiled. At St. Helena he again engaged in planting grapefruit trees (shaddock), sweet oranges, limes, avocado pears and bananas. It is said he shipped his oranges to New Orleans to sell for three cents each. He is credited with having grown the first grapefruit from seed and having planted the first orange grove in Florida.² Dr. Tebeau¹³ would not have classed Philippe as a "planter" for the records existent show that he never owned more than six slaves.

Although maintaining his estate on Pinellas peninsula he continued to operate his businesses in Tampa and owned a residence there. Simultaneously with the ending of hostilities in the Seminole Indian War an epidemic of yellow fever occurred at Fort Brooke in July, 1838. Many troops were moved away and economic hard times again settled on Tampa. The population of Hillsborough County dropped to 96 exclusive of the 356 members of the garrison at Fort Brooke. We have no record of how Philippe's business ventures fared other than that the Tampa Hotel, of which he was a stockholder, closed its doors in April, 1840. Perhaps the diversity of his enterprises permitted him to live fairly comfortably during this period. There is no record that he ever practiced



. . . In a Low, Oak-Covered Knoll
At Philippe Park

medicine or surgery in the Tampa area, other than on his family and slaves. After 1842 the Armed Occupation Act stimulated an influx of settlers by sloops, schooners, and mule-drawn, covered wagons, and another boomlet arose that was to be muffled by the Civil War.

Apparently for almost 20 years he lived in peace at St. Helena with his daughter Melanie, her husband and their children. Two of his daughters lived in Key West with their husbands and another daughter lived in Tampa with her husband. In 1841 he adopted a fifth child, Harriett Florence, who also grew up at St. Helena.

Tragedy, however, was to strike again for with the outbreak of the Civil War federal ships blockaded Tampa Bay and Union soldiers made forays on the shore to steal cattle and destroy property. For safety the family moved up the peninsula to a spot near the present Keystone Park in Pasco County.

The caravan was composed of two mules drawing a wagon and one horse harnessed to a big, clumsy, old buggy. A forerunner was mounted on Nellie, the saddle horse, and sent to a guard stationed at the head of Old Tampa Bay to find out if they could safely pass, that being the danger line. It was a long hard trip . . . The road, where one could be found, was composed of three trails: one in the middle for the horse to walk on and each side for the wheels, these trails were gouged by many and varied holes as the wheels rolled over pine and palmetto roots. The caravan reached Hernando County, a site near the present Keystone Park, Pasco County, (Pasco County was formed from Hernando County in 1887) after a week's journey.¹⁴

Here they built simple frame houses with dirt floors and enclosed them in a compound surrounded by a slat fence. Dr. Philippe, by now too old to engage in tending the cattle or to enlist in the Confederate Army, remained at the compound with the womenfolk and children while the younger men drove the cattle to supply beef for the Confederate Army. He busied himself in teaching the children reading, writing and arithmetic and in waiting on the medical needs of the community. He is characterized at this period as "a splendid doctor until his death, and always ready to help anyone in trouble."¹⁵

When the war ended the family made its way back down the peninsula to the homesite. The grove, though ill-kempt and partially burned, was coaxed back into production. This time Dr. Philippe established a residence in a cabin about

a mile inland where he was less annoyed by carpetbaggers and deserters. Each day, however, accompanied by a faithful Negro, Nelson, he rode to Philippe Hammock on the shore of the bay.

He lived in a small log cabin, the cracks being chinked with lime shell mortar. It was a comfortable room in which he lived, a porch on each end, with big doors opening on them; a big fireplace which extended across the end of his room and at the other end was a small window with a wooden shutter. His eyesight left him. . . . He could no longer ride his horse but was driven to his grove. . . . Sitting there, he would have them bring a gourd of spring water. He always said, "This is God's own country, and this water His medicine, stirred by His hand and deposited on this shore to heal man's suffering."¹³

In 1869 death finally came to Dr. Odet Philippe, friend of Napoleon, surgeon in the French Navy, plantation owner in South Carolina, pioneer citrus grower in Florida and first settler of the Pinellas peninsula. He is buried in a low, oak-covered knoll a short distance from the site of his original house. His grave is marked by a simple granite headstone.

The author wishes to express his indebtedness to Mr. Ralph D. Reed, Executive Director, Pinellas County Historical Commission, who supplied much of the information upon which this article is based. As the facts of Philippe's life are difficult to document, much of this sketch is based on family lore.

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John Perry Wall

A Man for All Seasons

JAMES M. INGRAM, M.D.*

A current Broadway play recreates the incredibly versatile career of Cardinal Thomas Woolsey in the Royal Court of Elizabethan England. The play's title, "A Man for All Seasons," is singularly apt for its subject, and is equally descriptive of the life of John Perry Wall—Tampa's most versatile physician.

The circumstances of his birth portended that he was to be no ordinary man. John Wall was born while his family was "under siege by the Seminole Indians"¹ on September 17, 1836, just south of the St. Mary's River, near present day Jasper, Florida. His parents, Mary H. and Perry Wall, were pioneers, migrating southward by wagon train from Georgia into Territorial Florida during the Second Seminole War.

The Wall family settled on a homestead near the site of the attack, and lived there for nine years. In 1845, lured by generous land grants of the Armed Occupation Act of 1842, the family again moved southward to establish and defend a homestead in the highlands of Hernando County, just north of Brooksville. Statehood was achieved by Florida that same year, amid continuing Seminole hostilities.

In these surroundings the family prospered, eventually building their estate, which was later called "Chinsegut Hill." This beautiful and perfectly preserved mid-century Florida mansion still dominates the rolling countryside from its highest point, and is now a biological experiment station for the University of South Florida.

Young John Wall received his early education in the local schools and aspired to practice the law; however, his father contended that medicine

was "a more congenial and profitable" profession.¹ His father's wish was dutifully honored, but the son's subsequent life was to evolve into a curious milieu of medicine, law, journalism and politics. He was graduated from the Medical College of South Carolina in 1858, returning to Florida only briefly before the outbreak of the Civil War. Volunteering as a Surgeon, he was assigned to Chimborazo Hospital in Richmond, which served the Florida troops in the Virginia area. While there, he returned briefly to Brooksville and married nineteen year old Pressie Eubanks, daughter of a wealthy planter, and took her back to Richmond for about a year.

Dr. Wall's daily log book of his years as a Confederate Surgeon, written in fine, delicate longhand, is preserved in Bradenton by his family. In addition to many medical descriptions, it provides a vivid picture of life in wartime Richmond. It also gives firsthand accounts of the tragic explosion of the Richmond Arsenal and of the construction of the first ironclad warships of the Confederacy.² Unfortunately for the historian, many pages of the journal portray only the anguish of a lovesick bridegroom, lamenting the paucity of letters from "my own sweet, dear, darling, precious Pressie" and pouring vitriolic abuse on the plodding postal service of the Confederacy. Chafing under hospital routine and the military discipline of the nearby Surgeon-General, Dr. Wall requested and was assigned duty with troops. He first served with the Eighth and then later with the Fifth Florida Battalion, ending the war as a Major in the Fifth Battalion stationed in Florida.

After practicing briefly in Brooksville, Dr. Wall and his family moved in 1869 to Tampa, an isolated, unpolished, cattle-shipping port of 1,500

*Presented before the Hillsborough County Medical Association, Tampa, May 3, 1966.

inhabitants. Here, in the course of a busy practice in 1871, he boarded the steamer H. M. Cool from Cedar Key, to treat a cabin boy critically ill with yellow fever. The cabin boy recovered, but Dr. Wall contracted the disease. From him it was carried to his family, and within a few days both his wife Pressie and their two year old daughter had died of the fever. This tragedy and the events that followed were to affect his life profoundly.

Already interested in communicable disease and problems of public health, he now devoted most of his time to the study of yellow fever. By 1873 he had reached the firm conclusion that yellow fever was carried by the mosquito, almost certainly, he thought, by the far-ranging "treetop mosquito," later to be identified as the *Aedes aegypti*.³ Without prior knowledge of the vector or virus, he came to this conclusion by three observations: (1) Both the mosquito and the disease were prevalent in the summer months and both disappeared with the first frost. (2) Adults whose work did not take them outside at night, when mosquitoes were most numerous, were rarely infected. (3) Children, who were generally kept in at night, with the exception of children of doctors and nurses, were usually spared.

He was the first American to make these remarkably accurate observations and conclusion. The mosquito had been incriminated as a vector by Daniel S. Beauperthuy, a native of Guadeloupe who settled in Venezuela, in 1854, but he had considered yellow fever a variety of malaria. Because of this basic error, his work had received little attention. It is not known whether or not Dr. Wall was aware of Beauperthuy's work. This was never mentioned in Wall's prolific writing on yellow fever, though he was generous in recognizing the work of others. For his conclusions on the mosquito, Wall received nothing but ridicule from the medical profession and especially from the lay press. The sanitarians held sway for more than two decades, and the most widely accepted opinion was that yellow fever would disappear with the elimination of filth. It was not until Carlos Findlay's proclamation in Cuba in 1881 against the mosquito, and later Walter Reed's final proof in 1900, that Dr. Wall's early conclusion was accepted. During this period, Wall, as health officer, had maintained yellow fever in Tampa to a notable minimum by mosquito protection alone.⁴

Throughout his adult life, Dr. Wall had suffered one regrettable weakness, a progressive



Chinsegut Hill, estate of Dr. Wall's family, built about 1850 on the highest point of land just north of Brooksville, is now a biological experiment station of the University of South Florida.

overindulgence in alcohol. Even by the loose moral code of a frontier town, he was known as "a hard drinker and a Hell-raiser."³ The death of his much beloved wife and daughter only increased this problem. Nevertheless, by 1872 he had successfully courted Miss Matilda McKay, the chaste and lovely daughter of Captain James McKay, a prominent shipmaster and exporter. Small wonder that when Dr. Wall approached the venerable Captain, asking for his daughter's hand, he was met first with stunned silence, then violent refusal. Given quickly to understand that the problem was his alcoholism alone, Dr. Wall swore never again to touch another drop if Miss Matilda would be his. In the face of direst predictions, and weathering provocative tests in which he was surreptitiously offered his favorite poison, Mint Juleps, by his doubting sister, Julia,³ he rejected alcohol completely. The couple was married, and to the best knowledge of every historian,⁵ his oath was never broken. He accomplished a one day cure of alcoholism, a rare and difficult feat in any age.

In this forthright decision, Dr. Wall shared in the strong personal characteristics of his entire family. His sister, Julia Wall Friebele,³ attracted only moderate notice in her simultaneous roles as pillar of the Methodist Church and a chain smoker of the finest Havana cigars. His brother, Joseph Baisden Wall, was a state's attorney, and later a judge and state senator. One day, during a brief trial recess, he stepped outside the front door of the courthouse, which now is the site of the Marine Bank. He noticed that the lynching of a white man was in progress under a large oak tree, known locally as the "Hangin' Tree," on present day Kennedy Boulevard. Observing that the members of the mob were unable to properly fashion a hangman's noose on the end of the rope, Joe strolled over and accommodately and expertly tied the knot, then returned to his duties in the courtroom.⁵ Personalities in the Wall clan did not lack for color.

At this point, probably aided by his abstinence, the most varied and productive period of Dr. Wall's life began. His photograph around 1875 shows him to be slim, wiry, and of medium height, with sandy hair and a neatly trimmed mustache. He was quick of motion and speech, and his alert gaze reflected his energy and wit.



Photograph of Dr. Wall in 1874, at age 38.

As Health Officer of Tampa, his chief interest and concern remained the field of communicable disease. In November, 1875, then a delegate to the American Medical Association meeting in Baltimore, he delivered one of the major addresses. It was entitled "Climatological and Sanitary Report of Florida,"⁶ a curious subject indeed by modern standards for presentation to such an audience. Yet, the Civil War was only ten years past, and Florida, with a population of only 187,000, was largely a vast wilderness which no one seemed able or inclined to use. Employing a remarkably broad vocabulary, Wall described the advantages of the topography, water supply, and climate. Together with Dr. Abel Baldwin,⁷ Wall gave the first proof, by extensive temperature observations, that the summers as well as the winters were milder in Florida than farther north on the continent. The paper received wide recognition and was reprinted in several medical and

popular publications. The subtle blend of scientific fact and hard-sell pitch for tourism and real estate, used by both Wall and Baldwin, would have warmed the heart of any Chamber of Commerce of today. In the same year, 1875, Dr. Wall attended the second meeting of the year-old Florida Medical Association, representing the "South Florida Medical Society" and presenting a paper on epidemic disease.⁸

An occasional glimpse of Dr. Wall's ever-present and often acid wit appears in the history of these days. When asked by a relative why he had become an Episcopalian instead of remaining in the Baptist or Methodist church of his family, he dryly replied, "I joined the Episcopal Church because it doesn't interfere with either my politics or my religion."⁵

Writing in his favorite sounding board, *The Semi-Tropical*,⁹ Dr. Wall displayed great foresight for the state. In his article entitled "South-west Florida," also in 1875, he enumerated Florida's chief needs: people for immigration, investment capital, disease control, harbor channels, land drainage, roads and railroads. On his own, he mapped out the exact routes used today by almost every modern rail line and major highway. His impatience with the delay in developing railroads and mail service to the West Coast was recorded with a bitter pen. His estimation of land use and land values of the various regions was extremely accurate, except for his opinion that the area from Bradenton south to the Florida Keys would never be "fit for anything else but grazing cattle."

During these years the Wall family occupied a house on the half block now occupied by the Tampa Terrace Hotel and the Tampa Federal Savings and Loan Bank. This plot, bounded by present day Kennedy Boulevard, Florida Avenue and Madison Street, contained the home, a large stable, and a separate office building for Dr. Wall. From this office, he carried on a very active private practice for over twenty years, a background easily overlooked among his many accomplishments. The only surviving child of his first marriage to Pressie Eubanks was John P. Wall, Jr. who grew up in this home, was educated as a lawyer, and practiced all of his life in Tampa. Of the children born to Matilda McKay Wall,

only one, Charley Wall, survived. He was to become one of Tampa's most colorful citizens.

Dr. Wall was asked to deliver the "Annual Oration," on the subject of his choice, to the Florida Medical Association Meeting of 1877. This address, covering many aspects of medical practice, gives, perhaps more than any other, the deepest insight into his character and the best cross section of medical knowledge of his era. It was certainly no whitewash of the profession. Wall held low regard for most medical therapy, particularly the value of the drugs then available.¹⁰ "Our stock of positive knowledge, as to the effect of drugs, is really much smaller than our professional vanity may be willing to confess. Is there any evidence that the average duration of life has been lengthened by our superior skill in the treatment of disease? On the other hand, is there not considerable ground for the belief that thousands of lives have been sacrificed by the exhibition of our remedies?"

He deplored the lack of scientific approach in evaluating therapy of all kinds and urged his colleagues "to glean the small grain of truth from the abundance of chaffy errors." He considered the prospect of preventing diseases far more promising, claiming that "we are much better prepared to exercise our knowledge in their prevention than their cure." The physician's image, as seen from the patient's eye, he found a bit too bright: "the truth is, the public faith in us as physicians far exceeds our ability—a fact whose recognition on our part . . . is likely to do more good for the advancement of the science of medicine than all of our boasted medical erudition."

On the positive side, he was fascinated by the possibilities of several new developments, particularly the recent use of the thermometer for the accurate measurement of fever. He lauded the perfection of "the hypodermic administration of remedies as another advance in practice, little if any, inferior to the use of anesthesia in surgery." He considered two new gadgets, the ophthalmoscope and laryngoscope, to have some promise. The greatest advance in surgery, he thought, was "the practice and teachings of Mr. Lister in the use of antiseptic dressings which strengthen the probability of correctness of the germ theory in the causation of disease."

Now his activities began to increase in scope and momentum. He became associate editor of the *Sunland Tribune*, predecessor of the present *Tampa Tribune*, in 1878, writing chiefly for his own amusement in the editorial pages. He delighted in controversy, and usually had arguments in progress with several other papers in the state. Dr. Wall so infuriated Colonel Frank Harris, editor and owner of the *Ocala Banner*, that the colonel challenged him to fight a duel. The challenge was accepted, but Dr. Wall stated that under the code, as the challenged party, he had the right to name the place and weapons for the encounter. He named Mrs. Bunch's Cowpens, near the Tampa slaughter pens on Six Mile Creek, as the place and shovels as the weapons. The state roared with laughter—and no more was heard of the duel.⁵

Later, as editor of the *Sunland Tribune*, Dr. Wall wielded his editorial scalpel on H. A. Crane, a former Confederate quisling, and later editor of *Key of the Gulf*, in Florida's largest town, Key West. Making a play of Crane's name, Wall called him "Old Yellow Legs" and the nickname remained with him until his death.⁵

From 1878 to 1880, Dr. Wall served as mayor of Tampa, concentrating particularly on increasing the maritime trade of the city. His portrait hangs appropriately in the City Hall among the mayors, rather than with his colleagues in the Medical Library. On completion of his term, he founded the Tampa Board of Trade, later the Chamber of Commerce, and became its first president. Here he was a strong leader in Tampa's three most important commercial developments. First was the construction in 1883 of the railroad from northeastern Florida to Tampa by H. B. Plant. The second was the settlement by Vicente Martinez Ybor and a large colony of Cuban and Spanish cigar makers in an area east of the city, which is now Ybor City. Third was the development of the phosphate industry, which began with the discovery of phosphate in the mouth of the Hillsborough River¹¹ during the deepening of the channel by the government dredge *Alabama* in 1883. These accomplishments, together with his unending efforts to deepen the ship channel from Tampa to the Gulf, resulted in

a marked similarity between the overlapping lives of Dr. Wall and Dr. Abel Baldwin of Jacksonville.¹²

The year 1885 found Wall at the zenith of his multifaceted activities. In a single year he served as President of the Florida Medical Association, a representative in the state legislature, and a delegate to the Third Constitutional Convention of Florida. On the floor of this convention, after years of unsuccessful effort, he led the final campaign to establish, in the state constitution, provisions for a state Board of Health. His most often quoted speech was an almost identical one presented before both the medical society and the convention. "The duty of preserving the health and lives of its citizens from the causes of disease is as incumbent on the state as that of suppressing rapine and murder. . . . One has no adequate conception of how much sickness and consequently death, are preventable. . . . The time is surely coming when preventative medicine shall have reached such a degree of perfection that the occurrence of epidemic disease will be felt as a gross reproach to the community which it assails."¹³

The Board of Health was authorized by the convention of 1885, but was not actually created because of the lack of money. The legislature of 1887 chose to ignore its constitution. Thus was perpetuated the system of individual community health control begun by the first Territorial Governor, Andrew Jackson, in 1821, when he created a Board of Health in the first ordinance governing his new headquarters of Pensacola. Subsequently, it had been the desire of each community to establish its own health authorities, regulation, and methods. As transportation improved, yellow fever increased to become the state's major health problem and its greatest barrier to economic progress. Epidemics appeared almost every summer in coastal towns in spite of constant pleading by Wall and others for state-wide regulation. Only the infamous "shotgun quarantine" by volunteer citizen-guards kept the fever out of inland communities.¹⁴ Finally, when medical problems became political issues, Dr. Wall's most cherished dream was accomplished. During the gubernatorial campaign of 1888, the



Sand Hills Hospital, near Jacksonville, was used for the isolation of yellow fever patients during the epidemic of 1888.

most severe yellow fever epidemic yet to appear swept through the state. The candidates, led by democratic nominee Francis P. Fleming of Jacksonville, were prevented by individual community quarantine, enforced by shotgun, from campaigning in many counties. A few days before the November election, which was won by Fleming, his brother, attorney Lewis I. Fleming, died of yellow fever in Jacksonville. Political and public sentiment was at a peak, and Dr. Wall relentlessly pressed the governor-elect for action.

Immediately after his inauguration in February, 1889, Fleming called Florida's first special session of the legislature. There could be no delay until the regular session in the summer, for fear that the epidemic would return. Despite considerable opposition, a State Board of Health was established and financed, and severe penalty

was set up for violation of quarantine and other health laws. Dr. Wall's one-man crusade of fifteen years was now successful. He was recognized, both immediately and to the present time, as the "father of the State Board of Health."

His close friend, wealthy and energetic Dr. Joseph Y. Porter, was appointed the first State Health Officer, his first of seven productive and distinguished terms. Dr. Porter later wrote of Wall in his history of the State Board of Health "this . . . stands as a lasting memorial to a man (Dr. Wall) of superior mental attainments and who, far ahead of his time, was looking forward to the future welfare and commercial prosperity of his state.¹⁵"

Victory in the Legislature did not slow the frantic pace of Wall's life. He returned to Tampa to enter still another civic controversy. Henry



St. Louis
Missouri
- 1910

On the
18th Day of April
1895

Go take action on

The untimely death of

THE FOLLOWING PREAMBLE AND RESOLUTIONS WERE ADOPTED.

And WHEREAS, While we sit to see through the infinite wisdom why he should have thus removed one so endeared to us, still as his humble servants we submissively bow to his divine will knowing that he doeth all things well. Therefore

RESOLVED

[illegible]

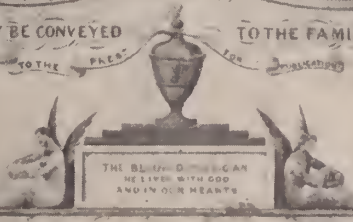
- AS A PHYSICIAN HE WAS ABLE IN HIS THOUGHTS ACCURATE IN HIS CONCLUSIONS AND TRUE TO HIS CONVICTIONS
RESOLVED, THAT THE PEOPLE OF HIS COUNTRY SHOULD BE KEPT FROM THE TROUBLE OF DISEASE,
AND ENJOY THE BENEFIT OF KNOWLEDGE.

His life as a Physician was one worthy of imitation.

[illegible]

RESOLVED That a Copy of these Resolutions be spread upon the minutes of this **ASSOCIATION**

AND A COPY BE CONVEYED TO THE FAMILY AND ALSO



715

B. Plant, having completed his railroad five years earlier, was embarking on his most grandiose and least practical venture. On the west bank of the Hillsborough River, he was laying out the foundation of a huge, almost unbelievable, Moorish castle, over two blocks long, and to be topped by 13 silver towers or minarets. It was to be the Tampa Bay Hotel, the epitome of subtropical resorts. But to the natives, it would have looked far more at home in Arabian Nights than among the sand-choked streets of Tampa. When the projected size and luxury of the new hotel were compared with that of the town, it appeared to them to be a clear case of the tail which would wag the dog. Popular sentiment was that of amusement and skepticism. Fearing that public ridicule might prevent the erection of this opulent oasis in the wilderness, Wall and other members of the Board of Trade exerted every effort to defend and support the hotel. It was completed, and was a monumental financial flop; but it made Mr. and Mrs. Plant happy, brought the rich and famous to town, created the most distinctive feature of Tampa's skyline, and eventually provided a campus for the University of Tampa.¹⁶

In October, 1893, Dr. Wall, by then an authority on yellow fever, was called by the Surgeon-General of the United States to consult in the management of yellow fever at the Maritime Hospital in Brunswick, Georgia. While there, he was summoned home because of the illness of his wife Matilda. He arrived only a few days prior to her death in November, 1893. Six months later he followed his father's example and took a third wife, marrying Miss Louisa Williams of Virginia in May, 1894. There were no children from this brief marriage.

At the annual meeting of the Florida Medical Association on April 18, 1895, Dr. Wall was invited again to be the guest speaker. The meeting was held in the hall of the East Florida Seminary, forerunner of the University of Florida, at Gainesville. An eyewitness account of the evening session is preserved in the Proceedings of the Florida

Medical Association:¹⁷ "Dr. Wall entering the hall, and it being a few minutes of the hour set apart for the consideration of his paper, the order of business was suspended, and to a very marked attention on the part of his confreres, the gentleman commenced reading his paper on 'Public Hygiene in the Light of Recent Observations and Experiments.' It was observed that he read with great difficulty and under suppressed excitement, the stress under which he seemed to labor being so great at times as to cause him repeatedly to pause and to sip water." Even then, his sense of humor did not fail. With the quip that "high tones and toney meals do not seem to agree with me," he tried to continue. "He had proceeded but a short distance, but eight or nine minutes having elapsed since he entered the hall, when he reeled and fell, striking the floor. . . ." He was dead before the presiding officer could reach him. Though likely due to coronary occlusion, the exact cause of his death was never established.

It was an age when public mourning was emotional and effusive; when journalism was florid, lachrymose and unabashed. A special train of three cars, draped in black and carrying an escort of over twenty medical leaders, carried his body back to Tampa. Along the hundred mile route, the engine whistle sounded long mournful blasts at regular intervals, a signal ordinarily employed during the winter to warn citrus growers of a freeze moving down from the North. In tribute, all businesses in Tampa closed for two days after the train's arrival.³

Newspapers of the state, even the Ocala Banner, competed in paying him eulogy. His own Sunland Tribune apparently felt no impropriety in describing the details of his widow's grief, or the features of his embalmed body and its good state of preservation. The Tribune hailed Dr. Wall as "a learned physician, a ripe scholar, a magnanimous man, a true friend of the poor, and one of nature's noblemen."¹⁸ The memorial resolution passed by the Florida Medical Association on the day after his death was inscribed on a

window-sized wall plaque, elaborately hand-lettered and decorated, and containing his portrait. This plaque now hangs in Tampa General Hospital, a gift from his descendants.

Today Dr. Wall's grave may be found in small, historic, century-old Oaklawn Cemetery, a half block island of cedar-shaded tranquility in the heart of busy Tampa. The quiet scene provides placid contrast with the hurried pace of Dr. Wall's life. He was physician, scientist, naturalist, industrialist, journalist, politician, humorist and crusader.

He was a man for all seasons.

Grateful acknowledgment for aid in preparation of this biographic sketch is given to James E. Wall, Jr., and Herbert G. McKay, both descendants of Dr. Wall, and to historian-journalist Hampton Dunn, all of Tampa.

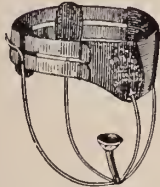
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Reprinted from the Atlanta Medical and Surgical Journal, September, 1885

Physicians, A Family Tradition

THERESA YAEGER PALMER and HUGH ARCHER PALMER

"Just before one of the [Civil War] battles, Dr. T. M. Palmer of Monticello, a division surgeon, had chosen a desirable location for his field hospital a short distance in the rear of General Robert E. Lee's army. Dr. Palmer had already arranged his tents and ambulances, with other surgical preparations so painfully suggestive to the brigade on the eve of battle, when an unassuming gentleman without insignia of rank rode up and dismounted as if he had come to stay.

"Approaching the intruder, Dr. Palmer courteously but firmly announced that he had selected that knoll as surgeons' quarters for the division and asked him to 'move on.'

"'Is there not room enough for both of us?' inquired the stranger.

"'No,' replied the surgeon. 'I fear there is not. Besides it might not be a pleasant place for you if you persist in remaining.'

"At this moment a staff officer rode up, saluted the stranger and handed him an official envelope and announced, 'dispatches for General Lee.'

"The surgeon was dumbfounded. Never having personally met the great Confederate leader, he stammered his apologies and began to vacate the ground.

"'Don't go, doctor,' interposed that hero of the nineteenth century, 'pray, stay where you are. I am sure there is room for both of us,' he added with a smile and a graceful wave of his hand."¹

The embarrassed Confederate surgeon was Thomas Martin Palmer, the first physician in a Florida family that has given the world fourteen physicians. Nine of them have practiced in Florida and three of them have served as President of the Florida Medical Association.

Dr. T. M. Palmer was born in the Pendleton District of South Carolina on January 6, 1821, and came to Florida with his family in a wagon train when he was about eight years old. He received his early education in Monticello and his degree in medicine from the University of Maryland School of Medicine in 1844. Except for the years he served as a surgeon during the Civil War he lived and practiced in Monticello. He occupied a home built by his father which is thought to be very similar to the old homestead in Virginia from whence his father came. This house, which still stands on the Palmer Mill Road, is now known as the Palmer-Simpson House. The first floor has brick walls two feet thick and the second and third floors are of frame construction. The windows are set in deep embrasures, there is a wide entrance hall with high ceilings, and the kitchen was originally placed away from the house to eliminate the danger of fire and the odors of cooking.

With the onset of the Civil War Dr. Tom was mustered in as a surgeon of the Second Florida Infantry,² and from 1861 to 1863 was surgeon in charge of the Florida Hospital near Richmond.³ On the closing of the Florida Hospital he became surgeon in charge of the ward assigned to Florida veterans at the Howards' Grove Hospital in Richmond.⁴ With the surrender at Appomattox, Dr. Tom made his way back to Monticello and resumed civilian life as a physician. Active in the early formation of the Florida Medical Association, he was elected President of the Association in 1876, following Dr. Abel Seymour Baldwin who had served two terms as president.

In his presidential address, delivered in 1877, Dr. Tom set forth the theory that malarial disease was due to the clearing of new land. "In the settlement of the West and Middle Florida, . . . there were so few diseases and cases of sickness that there was no data to base an opinion upon as to what particular disease or type of disease would prevail in the country; but as soon as the firm tread of the immigrant was heard in the land, and the 'axes were lifted up against the tall trees,' and forests were felled before the enterprising pioneer then was brought about one of those singular phenomenas so often following in the footsteps of our early settlers; then was developed those fearful epidemics of malarial disease, from which few new countries are exempt."⁵

Dr. Tom was married first to Jane Denham, and on her death, he married her younger sister, Jessie Denham. One son, John Denham Palmer, became a physician whose work during the Yellow Fever epidemic at Fernandina in 1877 is noted in Dr. Webster Merritt's article on Medicine in Duval County.⁶

Dr. Tom, eminent physician and illustrious public servant, died June 3, 1895, having practiced his profession for fifty years and served as Elder in the Presbyterian Church for thirty-five years.⁷

Dr. Tom had a younger brother, Dr. James Lawrence Palmer (1831-1901), who also became a physician and practiced for a while at Monticello, but later moved to Asheville, Florida, a small community "across the Aucilla River." He apparently also practiced as a country doctor covering, among other territory, the towns of Newport, Lloyd and Waukeenah. The authors of the history of Jefferson County, Florida, describe him thus: "He was kind, affable, considerate, and charitable. None but a Recording Angel will know how many kind deeds and comforts were rendered to suffering humanity by this good man."⁸

A third younger brother of Thomas Martin Palmer, Samuel Augustus Palmer, who was not himself a physician, became the father of Dr. Henry Edwards Palmer, who served as President of the Florida Medical Association in 1909. Dr. H. E. Palmer was born September 30, 1866 at Monticello, Florida, attended Jefferson Academy there, and worked in the dry goods store of Mr. J. H. Perkins until 1889 when the benevolence of his employer made it possible for him to enter



Thomas Martin Palmer, M.D.

upon his cherished ambition to receive a medical education. He thereupon entered the University of Maryland Medical School and received his M.D. degree in June of 1892.

When Dr. Palmer attended medical school the requirements for graduation were two years' attendance of six months each and the passing of a satisfactory examination by the school's faculty of nine members. There was an optional three years' attendance of one-half a year each, and this Dr. Palmer elected. His second year was spent as resident student, or intern, in the University Hospital, and he was appointed assistant resident physician after his graduation in 1892. He later resigned this position to accept a temporary appointment in the U. S. Public Health Service and command of a hospital ship off Fortress Monroe, Chesapeake Bay. This ship was commissioned to receive cholera patients evacuated from incoming ships. His tenure of service must have been short for on October 12 of that year we find the young doctor in Tallahassee substituting for Dr. George W. Betton while the latter took a vacation. Elect-



Henry Edwards Palmer, M.D.

ing to remain as the latter's associate, he fell heir to the senior doctor's practice upon Dr. Betton's death, November 1, 1896.

An interesting light is thrown on the economy of the time in reviewing Dr. Palmer's early records of his practice. Office visits were charged one dollar; city call, one dollar and fifty cents; country calls, one dollar for each mile traveled one way. (A country call of fifteen to twenty-five miles required from four to twelve hours.) The charges recorded in Dr. Palmer's ledger during 1897 and 1898 range from ten cents, to three, four and five dollars. One entry is ten cents; apparently paid for with eggs. The highest sum he credited was eighty-six dollars.

In a newspaper interview in Tallahassee on October 12, 1942, Dr. H. E. gives us a glimpse of his early practice. "When I started I engaged in general practice and that meant everything—obstetrics, surgery, eye, ear and nose, throat, foot, stomach, liver, heart, and all human body ailments. We didn't have specialists here in those days."⁹

Dr. Palmer performed the first appendectomy in his area when a forty-five year old lady called him to see her in Wakulla County about fifteen miles from Tallahassee. He had arranged for a local physician to assist him, but when this physician did not arrive, he placed her on the dining room table and put her to sleep with drop chloroform. Then, turning the chloroform can over to a neighbor lady, he proceeded to open her abdomen, evacuate an appendical abscess and remove the gangrenous appendix. She recovered uneventfully and was killed some twenty-eight years later in an automobile-train accident. Among his other firsts was the first removal of an ovarian tumor in the Tallahassee area. In his reminiscences he also recalls treating typhoid fever by the Brandt method. This consisted of immersing the patient in progressively colder tubs of water until the water had reached the temperature of sixty degrees. He notes that it was difficult to perform this treatment in the Tallahassee area when he first went there because there were few bath tubs available.

Dr. Palmer was a significant contributor to the Journal of the Florida Medical Association, having produced ten papers dealing with various subjects between the years 1910 and 1943. One of his favorite subjects was the effect of the black widow spider bite. He also contributed two very significant articles to the Tallahassee Historical Society Annual later known as the Apalachee. The first, in 1934, "The Proctors—A True Story of Antebellum Days and Since," was of a free Negro family. In 1939 he wrote, "Physicians of Early Tallahassee and Vicinity," which was published in 1944. Elected to the Vestry of St. Johns Episcopal Church in 1914, he later served as its Senior Warden for twenty-three years. He was a charter member of the Kiwanis Club of Tallahassee, and served as its president in 1931. It is said he never missed a church convention, Kiwanis Conclave, or medical meeting.

For diversion from his profession he managed an attractive farm near Tallahassee where he grew paper shell pecans and fruit trees. He also raised fowl, was a nature lover and was among the first collectors of antique southern furniture. Several pieces that once belonged to The Prince and Princess Murat remain in the collection he assembled. His home was his club and he was never

happier than when surrounded by family and friends. On the twenty-fifth anniversary of his entrance into medical practice he had as his table guests all the other physicians in Tallahassee, a custom which he followed on the thirtieth, thirty-fifth, forty-fifth and fiftieth anniversaries as well. On the forty-fifth anniversary he served "turkey with all the trimmings," along with crow and hawk; he expressed his disappointment at not being able to serve 'possum.

He was married to Maude Hamilton Myers in 1894 and she bore him four sons. After her death he was a widower for some years, then married Sarah Lucile Saxon in 1911, and from this union came two sons and two daughters. One of the sons of his first marriage, Thomas Myers Palmer, became a physician. Two sons from his second marriage, Dr. George S. Palmer and Dr. Martin Palmer (1927-) are physicians, the former a pediatrician in Tallahassee and the latter an internist in New Orleans, Louisiana. Dr. H. E. Palmer died March 22, 1944.

Starting one's medical career at age ten would be unheard of in Florida today, but Thomas Myers Palmer (1897-) did just that. A Negro presented himself at Dr. H. E.'s office about nine in the evening on a hot summer night. During a fight he had received a serious gunshot wound of the abdomen. After stripping the patient and laying him on the office operating table, Dr. H. E. had young Tom drip chloroform on a mask covering the patient's face while he cleaned the abdomen and performed a laparotomy. Dr. Thomas Palmer still recalls the hot night, made worse by the heat of a light bulb reflecting from a green glass shade, the odors of the scene, and the ordeal of replacing the intestines prior to closing the incision.

Dr. Thomas Myers Palmer received his early education in Tallahassee, attended the University of Florida, was Rhodes Scholar from Florida in 1918, and graduated in medicine at the Johns Hopkins Medical School in 1926. He took pediatric residency training at Johns Hopkins, and has practiced pediatrics in Jacksonville since 1930. He married Helen Theresa Yaeger in 1923; they have three children.

The eighty-ninth President of the Florida Medical Association, Dr. George Saxon Palmer, was born February 18, 1917. Graduating from the



George Saxon Palmer, M.D.

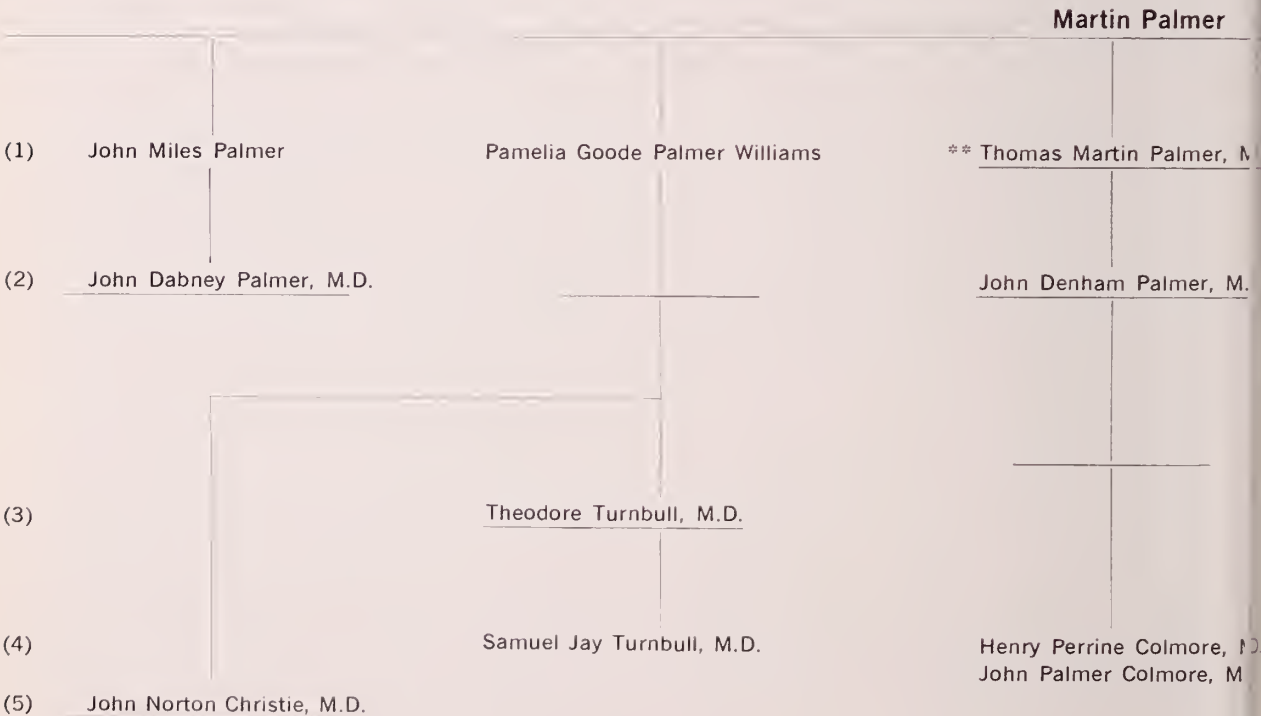
Leon County High School, in June of 1933, he entered the University of Florida and obtained his Bachelor of Science degree with honors in June 1937. In the fall of 1937 he entered the Johns Hopkins Medical School in Baltimore and earned his M.D. degree in June of 1941. After a year's internship in pediatrics at the Harriett Lane Home of the Johns Hopkins Hospital he entered the Medical Corps of the United States Army serving in the Third Army under General Patton. As many of our readers will recall, the Third Army entered Europe from the Normandy Beaches on August 1, 1944, and by August 13 had vanquished the cream of the German Panzer Divisions. It was they who drove Hitler from France. For his service in France, Luxembourg and later Germany, Dr. George received five battle stars.

The war over, he returned to Johns Hopkins in January 1946 as assistant resident in pediatrics. Following this he served a year as resident of the private pediatric service at the Harriett Lane Home and resident at the Sydenham Hospital for Contagious Diseases in Baltimore. He returned to Tallahassee to begin the private practice of pediatrics in February of 1948.

Dr. George Palmer has served his local hospital and medical society in many capacities including a year as president of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society. He served as member of the Board of

Medical Examiners of Florida for eight years and was president of the Board in 1958 and 1959. He served as a member of the Board of Directors of Blue Shield of Florida and as its Vice President from 1956 to 1962. At the 1965 meeting of the Florida Medical Association in Miami Beach, he was elected President-Elect of the FMA, and, upon taking office at the May 1966 meeting, he became the first son of a President of the FMA to follow his father's footsteps into this office. During his service in the United States Army he married Marie Margaret O'Leary, a graduate of Notre Dame College and the Johns Hopkins School of Nursing. They were married at the Dale Mabry Air Base Chapel at Tallahassee in August of 1943, and live in Tallahassee with their five children.

Other physicians who are descendants of the Palmer family are Dr. Theodore Turnbull (1860-1902), who practiced at Monticello and later at Jacksonville; and his son Samuel J. Turnbull (1886-1955), who served the U. S. Army during World War I and for some years thereafter. The two Turnbells, and John Norton Christie Jr. (1933-), the youngest doctor among the Palmer lineage, descend through the line started by a sister of Thomas Martin Palmer, Pamela Goode Palmer Williams. Dr. Christie practices as an internist in Jacksonville with the Riverside Clinic. A descendant of Joseph Palmer, a non-physician brother of Thomas Martin, is Dr. Margaret Palmer (1925-), an internist-cardiologist practicing in Ocala, Florida since 1953. A descendant of John Miles Palmer, Dr. Thomas Martin Palmer's eldest brother, was Dr. John



Underline indicates practiced or practicing in Florida
 Second President of FMA, 1876
 33rd President of FMA, 1909
 89th President of FMA, 1966

Dabney Palmer who practiced both medicine and pharmacy in Monticello and Jefferson County. Dr. John served as President of the Florida State Pharmaceutical Association in 1888, and was the author of a textbook of chemistry. Finally, two more physicians, Henry Perrine Colmore (1903-) and John Palmer Colmore (1921-), who practice in New York State and Oklahoma respectively, are descendants in direct lineage from Thomas Martin Palmer.

The practice of medicine as a family tradition is honored into and beyond the dawn of history. The Hippocratic Oath states "I will impart a knowledge of the art to my own sons, and to those of my teachers, . . ." ¹⁰ Perhaps the effect of heredity or the philosophic environment in which the child grows to manhood results in a penchant to help suffering mankind. Whatever the cause, many families have contributed unusual numbers

of physicians to society. Among the Florida families, the Palmer family has been one of the outstanding contributors to the medical community of our state.

Grateful acknowledgment for aid in preparation of this article is given to Dr. William M. Straight, of Miami.

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►Mrs. Theresa Y. Palmer, 1819 Goodwin Street, Jacksonville 32204

Amelia Miles

Joseph Palmer

Samuel A. Palmer

James L. Palmer, M.D.

*** Henry Edwards Palmer, M.D.

Margaret Palmer, M.D.

Thomas Myers Palmer, M.D.

*** George Saxon Palmer, M.D.

Martin Palmer, M.D.

THE JEFFERSON MEDICAL COLLEGE OF PHILADELPHIA.

The next second session of the Jefferson Medical College will begin on Friday, October 18, 1886, and will continue until the end of March, 1887. Preliminary Lectures will be held from Monday, 20th September.

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Roberts Bartholow, M. D., Dean.

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Reprinted from the Alabama Medical and Surgical Journal, September, 1886.

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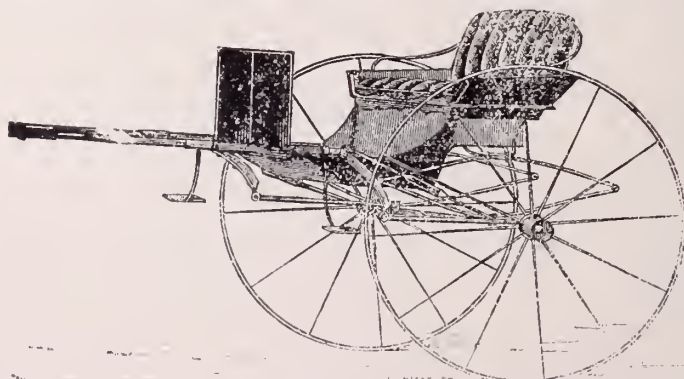
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Reprinted from the Weekly Medical Review, November 8, 1890.

Seven Years of Pioneering In Preventive Medicine

EDWARD R. SMITH, M.D.

Jacksonville, Florida was confronted with a grave problem. The 1909 mortality statistics as prepared by the Federal Bureau of Census listing Jacksonville's mortality rate at 27.6 per 1,000 population* had been widely circulated. This report threatened the economic life of the city, and it is reasonably well substantiated that life insurance companies were threatening to withdraw their coverage. The city administration, justly concerned, selected the first full time City Health Officer, the president of the Duval County Medical Society, Dr. Charles Edward Terry. This was a wise choice as Dr. Terry attacked the local health problems vigorously and scientifically, setting a pattern of public health procedures which has since been augmented, but not radically altered. After being given the oath of office on January 2, 1910, Dr. Terry began by delineating his problems.

The First Year (1910)

The first step was analyzing the causes of death in 1909, and deciding where his attack should begin. His analysis divided deaths into two categories—those from diseases which were noncommunicable, 699, and those which could be considered preventable, being due to infectious agents, 417. This latter category was subdivided into deaths from Food and Insect Borne Diseases, 139, from Contact and Air-Borne Diseases, 258. Also the stillbirth, neonatal, and infant mortality rates were analyzed, revealing 98 infant deaths under three months of age, and 76 deaths between three months and one year. This gave an infant mortality rate of 186.5 per 1,000 live births. The

stillbirth rate was also very high. Of 475 deliveries by physicians there were 38 stillbirths, and of 644 attended by midwives there were 109 stillbirths. This gave a stillbirth rate of 145.8 per 1,000 live births.

Further study of the deaths from infectious causes showed: tuberculosis, 165; gastroenteritis, 107; typhoid, 44; malaria, 35; tetanus, 15, and pertussis, nine. If each figure is multiplied by four it will show the impact of such a death incidence in Jacksonville today.

Following this analysis, Dr. Terry and his staff of sanitary patrolmen began concentrating their activities on those diseases which were preventable. He started strict enforcement of those sanitary laws already in existence, and urged the City Council to pass new ordinances. His staff increased its efforts toward home fumigation, mosquito control, quarantine, drainage improvement and fly control. In October he established a bacteriological laboratory and engaged W. G. McKay, M.D., as chemist and bacteriologist. Successful in securing a new milk ordinance, he engaged a milk sanitarian, and began the first laboratory examinations of milk, as well as food and water analysis. Results of these examinations revealed a portion of the city's water supply was contaminated, foods contained ferrous sulfate, candy contained paraffin, buttermilk contained formaldehyde, fresh milk had extremely high bacteria counts, and water had been added to over one-third of the milk samples examined. These findings resulted in strict enforcement of the new milk ordinance, and the beginning of inspection of food-service businesses.

In Dr. Terry's report to the City Board of Health in 1910, he requested a new program, that

*This figure was undoubtedly erroneous as a census six months later showed the population estimate to be approximately 9,700 too low. The corrected figure was probably nearer 21.02, still high when compared with the 1965 rate of 8.1.

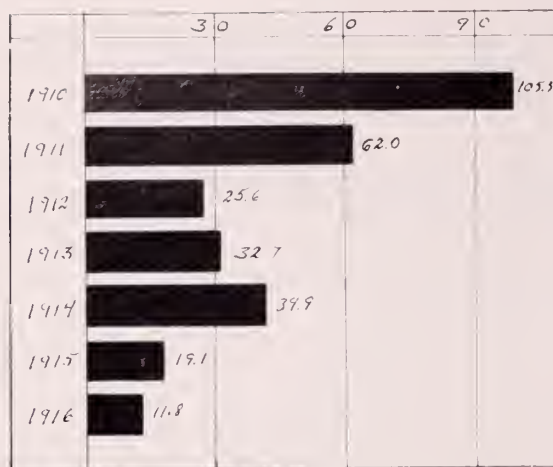


Fig. 1.—Typhoid fever mortality rates per 100,000 population.

of the physical examination of school children. His request was eloquently stated: "... among the advantages derived from a systematic medical inspection, is the education afforded both child and parent in matters of hygiene and sanitation. Public Health is of too great importance to any community to receive neglect at the hands of those to whom it is entrusted." The following year, 1911, Dr. James B. Parramore and Miss Jessie Wilson, R.N., were engaged to perform school examinations.

The Second Year (1911)

Dr. Terry secured an appropriation to establish a contagious disease cottage and secured a promise of \$50,000 to erect a contagious disease hospital building at St. Luke's Hospital. Because of an outbreak of rabies, he had an ordinance passed to restrict dogs running at large. Three human deaths had resulted from rabies, and 58 cases of canine rabies had been proven. Over 3,500 dogs were destroyed in controlling the outbreak. Dr. Terry recorded 158 cases of typhoid, a decrease from the 1910 figure of 329. He attributed this reduction to an active fly-control program.

The sanitation report for this year showed 218 houses had been placarded for contagious disease, 840 rooms fumigated, and insanitary earth closets found at 5,795 homes.

The Third Year (1912)

There was a further drop in the typhoid rate to 25.6 per 100,000 population, the lowest incidence in five years. Smallpox cases also diminished following a house-to-house vaccination program, as well as a general well-publicized program vaccinating over 30,000 individuals. Diarrheal diseases were made reportable so that these statistics could be used in combating those diseases which accounted for approximately 20% of all reported deaths. Tuberculosis accounted for 136 deaths, and the fact that these deaths were largely among the Negro population led to the formation of the Colored Health Improvement Association, and the employment of the first colored public health nurse.

Plague was discovered in Puerto Rico and Havana. To safeguard against its occurrence in Jacksonville, a bonus of five cents was placed upon rats brought to the health department. From July 14 to September 25, 1,528 rats were autopsied without evidence of plague being present. This plague scare resulted in an ordinance for rodent control being presented to the City Council, which declined passage.

A new subject, that of narcotic addiction, was added to the 1912 annual report. There was no effectual control of retail sales of narcotics and a regulatory ordinance was quickly drawn and passed. Dr. Terry recorded 551 users or 0.78% of the city's population. The health department

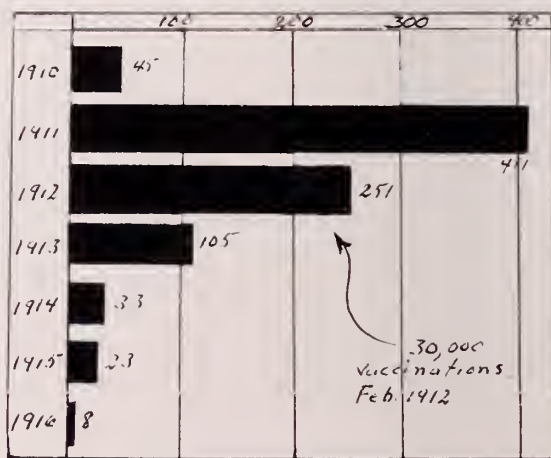


Fig. 2—Smallpox cases.

gave narcotics free of charge to the habitues to prevent illicit sales and used this opportunity to study the causes of addiction.

The Fourth Year (1913)

Tuberculosis was again the chief individual cause of death with a total of 160 or a rate of 238.1 per 100,000 population. Typhoid cases continued to decrease with a death rate of 23.8 per 100,000 population as contrasted with the 1910 rate of 106.3 per 100,000 population. Dr. Terry considered the constant reduction in both cases and deaths from typhoid entirely due to the protection of human excrement from flies as no other major source factor had been changed. Only 65 cases of smallpox were reported, and no deaths occurred.

The isolation pavilion at St. Luke's Hospital with 43 beds was completed by the City. It was adjudged the most modern in the South and it was here that the first application of aseptic nursing techniques in this area were practiced.

An important step was made in the passing of an ordinance to regulate midwifery. This required examination and licensing with instruction by the health department.

The Fifth Year (1914)

The lowest infant death rate yet recorded, 94 per 1,000 live births, was attributed to a visiting nurse's service and the Midwifery Ordinance.

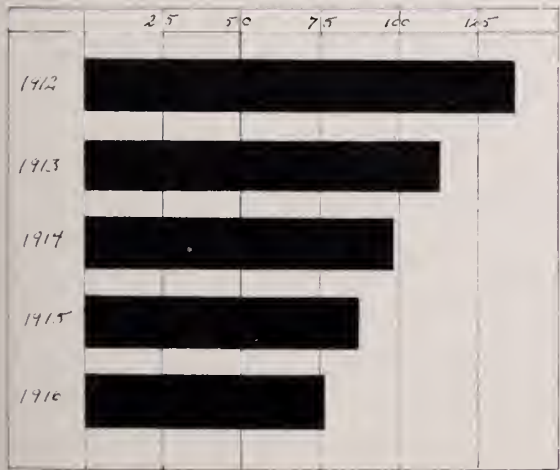


Fig. 3.—Infant mortality rates per 1,000 births reported.

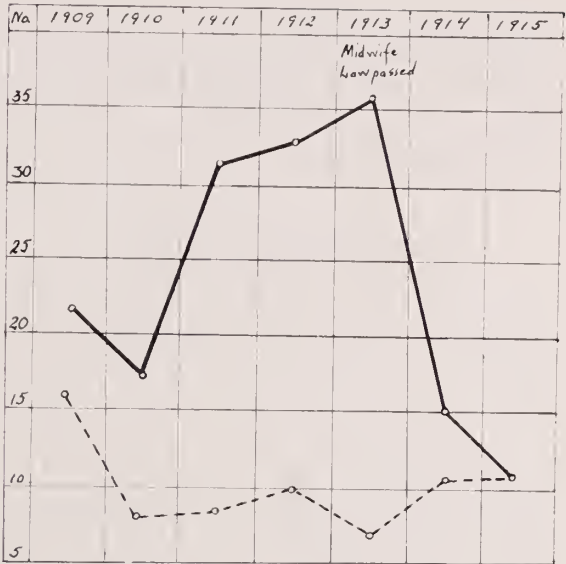


Fig. 4.—Deaths during "Tetanus Period" 5th to 18th day. Solid line—births attended by midwife. Broken line—births attended by physician.

The American Public Health Association held its 42nd annual meeting in Jacksonville, with the program being centered on Southern public health problems. In child health conferences conducted during the meeting, the better teeth of Jacksonville children was noted as compared to those of Atlanta, Knoxville, Peoria and Toledo. No valid explanation was given. (The benefits of naturally fluoridated water were unknown).

The file on narcotic users now contained 1,073 habitues. This number was believed to be low as many of the drug addicts purchased their supply by mail.

The Sixth Year (1915)

A death rate of 19.1 per 100,000 population was the lowest death rate from typhoid recorded—92 cases, with 14 deaths. Pellagra assumed new importance as a cause of death with 51 deaths for a mortality rate of 69.7 per 100,000 population. The highest rate previously was 24.9 per 100,000 population. This increase was attributed to a financial depression which greatly affected the area.

The infant death rate continued to decline, the rate being 82.9 per 1,000 live births.

The Congress adopted the Harrison Narcotic Act, and Dr. Terry successfully urged the State Legislature to pass stringent laws supplementing this Act.

A wide reorganization of the health department was urged, placing emphasis on health education in the home. To accomplish this, Dr. Terry urged an increased nursing staff with less emphasis on sanitary inspections.

The Seventh Year (1916)

Only four cases of smallpox, with no fatalities, were reported. Diphtheria dropped to a new low point, with only 69 cases. The typhoid rate also was at its lowest, with a death rate of 11.8 per 100,000 population—56 cases with nine deaths. No change was noted in the tuberculosis rate, and Dr. Terry decried the lack of hospital facilities and home nursing service required to attack this disease effectively.

The health department staff made a complete city survey, plotting areas of high disease incidence, noting the sanitation conditions in these areas and emphasizing that these areas supplied a high proportion of the domestic servants and food handlers for the city.

As City Health Officer, Dr. Terry was paid \$3,000 annually, and when he was offered the position of Health Editor of the Delineator Magazine, he accepted, and submitted his resignation, effective January 6, 1917.

No question can ever be raised as to the wisdom of spending the \$21,000 for seven years of brilliant public health leadership. The charts (figs. 1-4) illustrate, far better than any narrative, the impact that this dynamic, wiry, heavily moustached, slightly built man had on the health conditions of Jacksonville. In Dr. Terry's final annual report (1916) he stated: "Remember that public health is purchasable. You may buy much or little." With its purchase of this man's talents, Jacksonville bought much.*

*Charles Edward Terry, M.D. Born Hartford, Conn., 1878. Died, Wingdale, N. Y., February 18, 1945. Graduate, University of Maryland School of Medicine, 1903. At St. Luke's Hospital in Jacksonville, served as Chief of Medicine, 1908, and Chief of Contagious Disease Department, 1915-1918. Member AMA; FMA; President, Duval County Medical Society, 1910, Charter Fellow of APHA, Vice President, 1915, on Governing Council APHA, 1915-1926. Charter member of the Florida Anti-Tuberculosis Association, served on its Executive Committee. Served as Executive Director of Committee on Drug Addiction of Bureau of Social Hygiene, 1923; later served at Harlem Valley State Hospital where he died.

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Reprinted from the American Medical Digest, August 15, 1887.

The Great Voyage

CLIFFORD C. SNYDER, M.D.*

God is in His Heaven. So begins the physician's narrative of the First Crossing in 1492. The source material portraying this historical adventure is plethoric, yet there remain many tributaries to be venesected, typed and cross-matched. Admiral Samuel Eliot Morison, historian-laureate, tapped the capillary nidus of discovery by following the wake of the Santa Maria through the exploring voyage of the Harvard Columbus Expedition in 1939.¹ Captain Louis H. Roddis, retired U.S. Navy physician who saw active duty in both world wars, has retrieved specific specimens of historical interest and related such in books and articles.² Dr. Roddis recently aided me on a specific item for this writing. Marion and Ed Link, the famous husband-wife team of adventure and discovery, recently produced a caput medusae of collateral navigation upon describing a new and different landfall of Christopher Columbus' initial sea trip to the New World.³ This pleasant pair of modern mariners gave freely their time in my behalf. Mendel Peterson, head curator of Armed Forces History at the Smithsonian Institution, rendered a manuscript and photographs which helped me.⁴ This fivesome of authors may be likened to the lead beads of a monk's rosary of which there are numerous segments; so may pardons be granted by those remaining beads who deserve recognition but acknowledgment is forthcoming.

This Great Enterprise, as Columbus desired it to be known, is most exhilarating not because it occurred, but because it may never have happened if physicians were not involved with certain humanitarian concessions as well as judicial decisions dependent upon its success.

During the latter part of the fifteenth century the great intellects of Western Europe were profoundly pessimistic of their generation. They were aware of the decadence and jejuneness of institutions of learning where traditions were being thrown to the wind. They were incited about the diminishing prestige of Christendom at the expense of the Turkish infidels. This was an era of restless energies and civil tumults, as well as pestilence and famine. Is it any wonder, with these existent conditions, that Columbus' oceanic adventure ever transpired?

Incidentally, the discovery of the Western World by this navigator was strictly an accident. He died unaware of his ostentatious accomplishment. Today he is respected for achieving something he never purposefully sought, but his accomplishment is recorded as the most spectacular geographical discovery in human history—and you as an American better believe it!

For two centuries following Marco Polo's overland journey to the Orient in 1275, the people of Europe larynxed lyrics and spun yarns of the wonders and splendors of Kublai Khan's Cathay in the East. There were whispers about jewels, silks, spices, drugs and rare perfumes which only rich Europeans could afford, yet they were plentiful among the peasants of the Indies. The Italian merchants who paralleled Marco Polo's land route eastward soon wished they had legs like ostriches to challenge the distances. Although they domesticated their allergies to the heat of the desert sands, linimented their muscle spasms to the irregularity of the rugged mountain heights, and equilibrated their vertigo to the turbulence of the seas, they could not allay their fears of constant pirate raids and loss of merchandise along the tortuous return route. These rich-to-be tinpan

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alley tradesmen dreamed of a short, direct and safe Lincoln Road Mall to and from the great markets of Asia. You will remember that it was in 1453 the Turks seized Constantinople, and while the Ottoman rule was being established the last caravan of merchants and mules faded with the setting of the western sun. So ended the odors of oriental incense and the precious particulars that Europeans longed for but could not purchase elsewhere. The loss of the overland trade

route fanned the fervor to find a trade-way by sea to the East Indies.

Most of the cosmographers and cartographers of Europe were convinced that the earth was a sphere and that a route westward across the Atlantic would lead to the East Indies (India), Cathay (China) and Cipangu (Japan). The Portuguese navigators had sailed a westward course and discovered the Azores, but none were brave enough to continue west into what mapmakers



Fig. 1.—This picture of the oldest globe in existence was made in 1492 by the German Martin Behaim. He positioned Asia where North America is and placed Japan in the Atlantic. Antillia, the mythical isle, is also represented.

designated the Sea of Darkness. To many seafarers the thought of going west to get east was but a mariner's nightmare. To Columbus this was no dream complex, but a definite reality. He had not been in the Portuguese Merchant Marine for the folly. He sailed from Lisbon to the Azores and from the African coast to the Arctic Circle on many trading expeditions and was the skipper on many of the sailing vessels. Although celestial navigation was in its infancy, Christopher could chart latitude from the stars. He could split a sphere into three hundred and sixty degrees, but was in error in thinking a degree was forty-five nautical miles while in actuality it is sixty sea miles. This difference almost caused him a mutiny on his first enterprise westward. He was so determined and so cocksure that he could sail straight west to India that he Z-plastied the degrees of distance to conform to his thinking and tailored the Atlantic Ocean to the measurements of his desire. Columbus unknowingly underestimated the circumference of the globe twenty-five per cent! Lest you misunderstand, the many nautical derivations of Columbus were not impromptu, but were results of his intensive readings and studies which the scholars of the day preached and published (fig. 1). The warp and woof of this loom of oceanic history is interlaced with an interstitial reticulum of medical aspirants all of whom are responsible for specific tributes to the permanent success or temporary failure of Columbus' sea vision.

One medical authority who played an early part in encouraging the future adelante to undertake his westward enterprise was the Italian, Paolo dal Pozzo Toscanelli. Master Toscanelli was born in Florence in 1397 and died in 1482 at the age of eighty-five. As a youngster he spent many hours watching the merchants arrive from the Orient, unload their wares, and display the elegant commodities at the bourse or market square. He listened to their treasure tales and although the prolixity was productive of ischial ischemia to most of his playmates who would take leave, he lingered attentively to the end. Upon reaching home at night, he would carefully record on parchment the expressions he heard as well as compose charts of the journeys he remembered. He labeled the countries, cities, mountain ranges and seas while musing of the day that he would



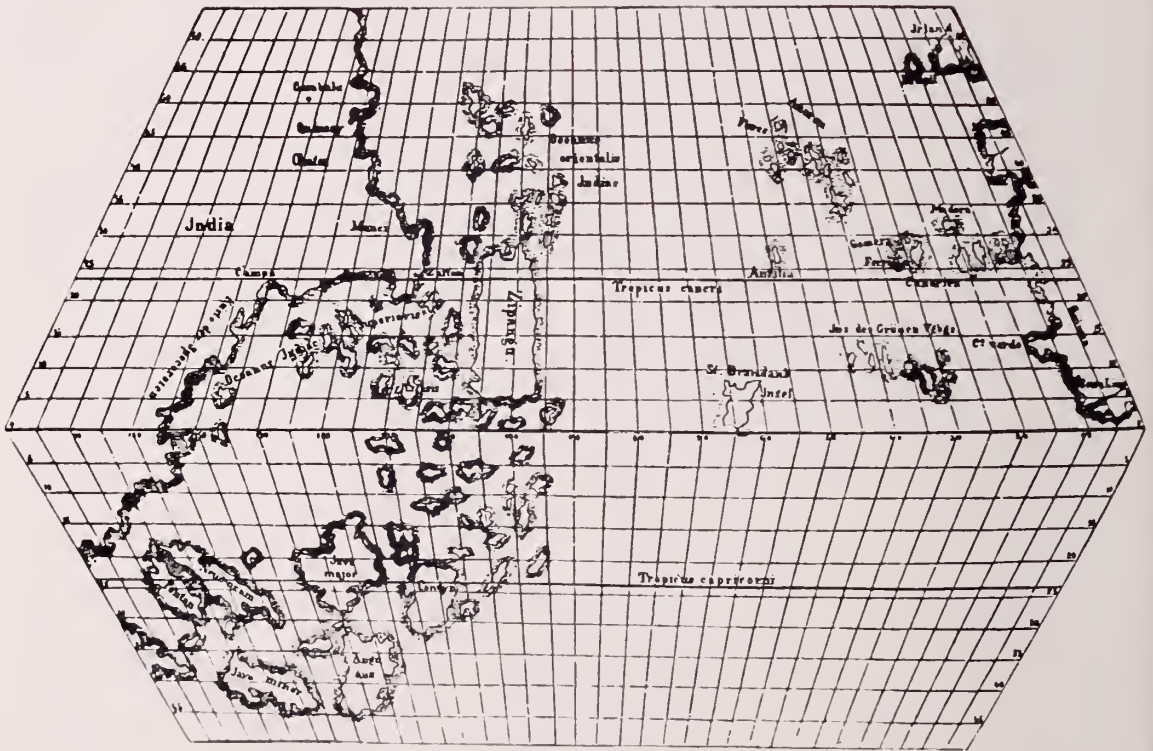
Fig. 2.—A likeness of Master Paolo Toscanelli, the Florentine physician who stimulated Columbus in clearing a channel from the ancient Mediterranean Sea to the Modern Caribbean Sea.

travel the same route. Would you believe that Paolo knew every merchant and caravel and caravan worker by name! Although the young Paolo grew to become a guild surgeon, he also became widely known as a mathematician and astronomer (fig. 2). Master Paolo was reputed to know "more regarding geography than any man in the world." The reason that the fifteenth century physicians developed such a vast knowledge of astronomy was that most of their concocting and administering of medications were according to the lunar cycle, the celestial positions and the signs of the zodiac.

Master Paolo Toscanelli corresponded frequently with a friend, Fernao Martins, who was a canon in the Cathedral of Lisbon. King Afonso of Portugal had heard of Toscanelli and requested Canon Martins to acquire information from the doctor as to the reasoning for a possible westward route to the Orient. On June 25, 1474, Toscanelli answered Canon Martins' letter which requested the data that the King wished. He enclosed a chart that he had drawn with illustrations of a course due west from Portugal. The map was drawn with parallels of latitude and meridians of

longitude (fig. 3). He marked landfalls along the voyage which he calculated to be about five thousand nautical miles to Cathay (China). Toscanelli, learned and honest as the ninth commandment, was regrettably mistaken regarding the eastern shore of Asia. If he had only changed the wording from Asia to America, his calculations would have been dead right. Master Paolo included in his letter an alternate route with the destination as Cipangu (Japan), which he measured at about two thousand miles. The doctor then terminated his letter to Canon Martins by remarking, "Thus, by the unknown ways there are no great spaces of the sea to be passed . . . the King would rather work out these (few details) for himself."

In 1481, Columbus learned of this correspondence and hastened to write Paolo Toscanelli in query of similar as well as additional information. Christopher sent along a small sphere which illustrated his design of the world. Master Paolo responded to the mariner's requests with two known letters. The first began, "Paolo the physician to Christopher Columbus, Greetings. I perceive your noble and grand desire to go to the places where the spices grow." The letter ended, "I am not surprised that thou, who are of high courage, and the whole Portuguese nation who have always been noble men in all great enterprises, should be inflamed and desirous to prosecute the said voyage." The doctor wished to encourage the sea captain; so he included a copy of the letter he



This is a restored version of the map Toscanelli sent Columbus in 1481. Like the Behaim globe, it places Zipangu (Japan) near where America was to be discovered.

Fig. 3.—A version of the world that the physician Toscanelli constructed and enclosed in a letter to Columbus in 1481. Toscanelli's India is our America and his East Indies are today's West Indies.

wrote Canon Martins for delivery to the Portuguese monarch. He also sent a sea chart which he drew himself and which positioned Cipangu in the middle of our America. Toscanelli believed in the existence of the mythical island of Antillia, which was supposedly inhabited by seven Portuguese bishops. For your pleasure, the last of these phantom islands, the Brazil Rock, was not deleted until 1873 from the Admiralty charts. Master Paolo's second letter to Columbus was one of fatherly advice. He wrote, "When that voyage shall be made, it will be a voyage to powerful kingdoms and noble cities and rich provinces." He suggested carefully planned approaches to the rulers of the lands to be visited in order that knowledge could be gained from the learned men in the areas and friendly relations stressed on matters of religion and future trade and travel. The physician was a master mapmaker and included charts for Columbus' perusal. These letters enthused the future discoverer to nearly a fanatical state. He later used them for "selling his idea to King Ferdinand and Queen Isabella." The Admiral packed the letters in his sea chest and referred to them frequently on his first voyage when he became exhausted and depressed. Columbus prized these letters of Toscanelli more than lay authors infer because he even displayed them before the court as evidence during his trial in later years against the Spanish Crown. Doctor Paolo dal Pozzo Toscanelli, the popular Florentine, was the first of many known men of medicine who actually participated in events that led to the discovery and eventually colonization of the New World.

From the fall of 1476 until the summer of 1485 Christopher Columbus lived on Portuguese soil, and many stirring events transpired during this short decade. He became associated with his brother Bartholomew in a cosmographic and cartographic establishment which expanded from a small "hole in the wall" to a very successful atelier of charts, materials, references and maritime services. This experience as a map and chart artist indubitably benefited Christopher to become one of the greatest Admirals of all times. "Columbus," Ferdinand quoted in his biography, "was so strict in matters of religion that for fasting and saying prayers he might have been taken for a member of a religious order."⁵ He routinely

attended mass at a chapel constructed by a group of cavaliers so their women might pray while the men were away fighting for their country. At this Convento dos Santos in Lisbon, young Columbus first devoted his attentions to and later wed Doña Felipa Perestrello e Moñiz, who was a member of a very noble Portuguese family. They voyaged to Porto Santo, near Madeira, where Doña Felipa's brother was Governor. There, in 1480, a son was born. The church where he was baptized, Diego Colón, still remains.

In 1481 Prince John II succeeded his father to the throne of Portugal, and it was under this nephew of Henry the Navigator that Columbus enjoyed various roles as navigator, pilot, or captain on numerous trading voyages ranging from the Arctic Circle to the African coast. If doubt existed regarding his abilities as a seaman previous to this, you now could safely wager that the experience he gained on these trading expeditions instilled the confidence he needed for his Great Enterprise. King John II must have had faith in him, because in only three years Columbus became the Commander of a fleet of royal ships. If you be among those that believe in intuitive cognition, then you will consider the possibility that Christopher Columbus regarded himself an intuitionist and that he was celestially designated to augment the periphery of the fifteenth century world.

Among the many councils and cabinets that the recently coronated John II appointed was the Junta dos Mathemáticos, which currently would be known as the Maritime Advisory Committee. This council was to become the most powerful advisor to the throne on principles in navigation and discovery. When Columbus gained an audience in 1484 with King John and presented his plans of reaching India by sailing west, the king showed considerable interest and referred the project to the Junta for review and advice. Two honored members of this majestic advisory board were physicians.

One of the two, Master José Vizinho, had been a student of Rabbi Abraham Zacuto, the famous Salamancan mathematician. Master Vizinho was not repositioned to any of the nobles at court. Besides having translated Zacuto's astronomical calendar, Vizinho was given the arduous task of plotting and assigning specific latitudes along the

African coast to improve Portuguese navigation and possibly enhance a short route to India. Although Christopher had tactfully presented his enterprise to the Junta, he met great opposition from Doctor Vizinho.

The second physician member of the Junta was Master Rodrigo, the personal physician of King John himself. This learned doctor had gained navigational notoriety by many personal contributions, but probably was better known throughout Europe for his construction of a simple astrolabe. This pilot's aid is an instrument used to observe positions of astral bodies in measuring the meridional altitude of the sun. The two physicians, Vizinho and Rodrigo, objected to the plans on technical grounds that the distance calculations were erroneously underestimated and that the Genoese navigator insulted Neptune by making a "lady lake of this great domain of sea and ocean." The strongest exhibit that Columbus presented before the Junta was the Toscanelli letters. He was ridiculed by Bishop Diogo Ortiz de Vilhegas, another member of the Junta who was a theologian, geographer and personal counselor to King John. This clergyman, who is also known in history as Doctor Calzadilla, addressed the now humbled Columbus as a "boastful imaginative, demanding mariner that exhibited little respect for the King and less for the lives of the subjects who might accompany him to the bottom of the sea." Columbus' son, Ferdinand, retaliated to these statements in his biography by suggesting that some might have thought his father boastful and demanding, but he was a man of "great honor and advantage and it was necessary that he act as such in order to have his reputation and the dignity of his house conform to the grandeur of his word and of his merits." Unfortunately, Columbus' enterprise was vehemently rejected as apocryphal.

The Portuguese events terminated in 1485. Expenses to promote his enterprise outweighed his savings and soon Christopher was set upon by debtors. His wife, Doña Felipa, died the same year and so he decided to sever his relations with Portugal and take passage for Spain with his five year old Diego. The morose Columbus camouflaged his melancholic state by reminding himself that there must be other magistrates in Europe ready to listen to his enterprise. Christopher was

a man of spirit and his actions were always cephalad, not caudal. Upon arrival at the Spanish port of Palos, it is said that father and son walked four miles to La Rábida where there was a Franciscan monastery. Whether this was by design or by chance was not important, but the hospitality of the friary of Minorites was pertinent. The custodian of the monastery offered food, drink and rest to the tired couple. During this initial acquaintance over the dinner table the friar became interested in the seafarer and his son. The friar, Antonio de Marchena, was highly regarded as a teacher and astronomer. He accepted Diego as a student at the friary and was instrumental in furthering Columbus' enterprise. Friar Antonio introduced the navigator to Don Luis de la Cerda, Count of Medina Celi, a wealthy shipowner of Cadiz and a friend of the Spanish sovereigns, Ferdinand and Isabella. The Count decided to equip three or four caravels and support Columbus' project, but upon requesting the Crown's permission, Medina Celi was rejected the opportunity. Queen Isabella ordered the mariner to court for an audience, but because of pressing circumstances of state and a war with the Moors, the interview did not mature for almost nine months.

During this interval Christopher became acquainted with an apothecary in Cordova. Apothecary shops were sites for physicians and scientists to convene socially and converse. The proprietor of this shop was the intermediary between Christopher and a pretty country lass of twenty, Beatriz Enriquez, who became Christopher's mistress. Beatriz's family were close friends and neighbors of Master Juan Sanchez, subsequently to be the surgeon of the Santa Maria. Beatriz became the mother of Christopher's second son, Ferdinand. This son was to be the biographer of his father's life and also the most important source regarding the discoverer and the discovery. Some authors have designed Columbus as a romantic rogue and expressed great concern that he never wed the country maiden. Apparently the mariner shared a similar concern, as he provided for Beatriz in his will. Let us leave this romantic aura for the more pious persons who engage in personalities to vilify.

It was the first day of May in 1486 at the beautiful Alcazar of Cordova that Columbus was granted his long-awaited reception by the Catholic

Monarchs of Spain. Isabella's marriage to Ferdinand was the scaffolding in the architecture of Spain's strongest empire. Although this Lady of Spain was not aware of it, the man she was to give hearing this May Day was to be indirectly responsible for the future plate fleet of galleons laden with gold and silver from the New World that would bulge the coffers of Spain with gold doubloons and silver pieces of eight. It would be difficult to deny that the character-similarity of the auburn-haired blue-eyed magistrate and the red-headed light-eyed future Admiral did not have a bearing upon the Crown's decision to help the sailor (fig. 4). The entire court present at this first meeting of the Monarch and the mariner appreciated the mutual admiration of these two. Her Majesty expressed interest in the enterprise and appointed Fray Hernando de Talavera, her own confessor, as chairman of a commission to evaluate the project.

The Talavera Commission was unable to reach unanimity and postponed its report. Christopher became apprehensive and restless, so he wrote John II of Portugal regarding an audience. The

Portuguese Monarch answered immediately granting Christopher's request. King John had sent Bartholomew Diaz on another effort to circumvent the cauda of Africa and establish a route to India, but the explorer after one year was thought to be lost. Unfortunately, Christopher was present in Lisbon to see the caravels of Diaz arrive with news that they had rounded Africa and found a route to the east. King John II now lost interest in Columbus' speculations; so the shipless navigator returned to Spain. In 1490 the Talavera Commission concluded its report and the bewildered Christopher was humiliated again. The Genoan had experienced many insults from the Spanish subjects and, because of his current depressive mood, decided to approach the French Crown. When Christopher arrived at the La Rábida friary to retrieve his now ten year old Diego, Father Juan Pérez, prior of the friary and former confessor for the queen, asked Columbus to remain long enough for him to request another interview with Isabella. Father Juan did not want Christopher to forsake Spain for another crown, and so he attempted to delay the mariner's actions until word from Isabella was received.

The padre knew that the navigator's greatest interest in life was his Western Enterprise and with little stimulus he would rapturously discuss his project with anyone who would bend an ear. So Father Juan invited his close friend Doctor García Fernández to dine with him and Columbus. The physician practiced in Huelva, a village only an hour away via burro. Master Fernández promised Father Juan that he would bring his poke of maps and compare latitudes with Columbus. What an evening that would have been to witness! Friar Juan played the role of a referee but actually was a kibitzer in disguise. Columbus, you would have said, was not exactly a brilliant man, but on occasion elevated his thinking to the stratum which less-instructed minds have not had the pleasure to achieve. Master Fernández would have been your choice as a family physician with his panatela-like contour and lovable bedside mannerisms. This sage was also a mentor of cosmography and geography. The evening of consultation had barely begun for this trio of arm-chair conquistadors before the morning was announced by Helios driving his four horse chariot of sunrays through the chapel's apertures. This

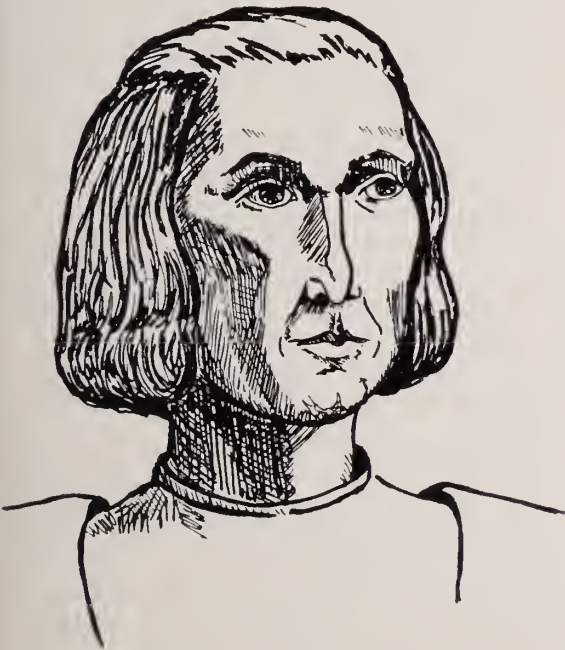


Fig. 4.—The young Christopher Columbus was a man of more than average stature, his face long, the nose aquiline, the cheek bones high, the eyes blue, and the skin of florid hue with little resistance to epitheliomas.

momentous evening will remain as one of historical importance. The padre achieved his goal by pleasantly keeping the navigator incarcerated on Spanish soil; Columbus' maps, charts and destined routes were audited by master cartographer Fernández and found to be valid; and Christopher acquainted a life-long friend in the person of this physician which proved true during the court trials to be encountered in the future (fig. 5).

Father Juan's request was permitted by the queen and in December 1491 Columbus appeared before the court. This time the Talavera Commission granted its formal consent for the great enterprise, but the Royal Council of Castile refused it. The Commission, which was composed of scientists and technical experts, gave its permission for the adventure. The Council consisted of superior theologians, ranking clergymen and grandees who govern appointments, titles, revenues and rewards. This group reported that Columbus demanded three fully manned and provisioned caravels supplied with trading articles to last one year; that he be knighted and his descendants be styled Don; that the rank of Admiral be bestowed upon him; that he be made Viceroy and Governor of all the land he discovered; that he be given ten per cent of revenues and metals brought from these lands; and, that he be the executor of twelve per cent of the trading, freighting and shipping with these new lands. Only after these demands were satisfied would Columbus allow discussion of rewards to the Crown and Royal Council. These exorbitant stipulations must have infuriated the Council because the request was strongly refused. This negative answer was the result of Columbus' waiting six years under the Spanish flag.

Columbus, feeling usurped, arranged travel for his eldest son Diego to his wife's sister at Huelva. Ferdinand, his youngest, was safely in the arms of his mother in Cordova. The sinister sailor then set out for France straddling a burro and riding at a turtle's trek. His trip was altered when a royal messenger corralled him and his beast of burden four miles out on the highway to Versailles. He was commanded to return to her Majesty's court without display of words. Columbus was to learn that the royal treasurer, Luis de Santangel pleaded with and finally persuaded King Ferdinand and Queen Isabella to grant Christo-

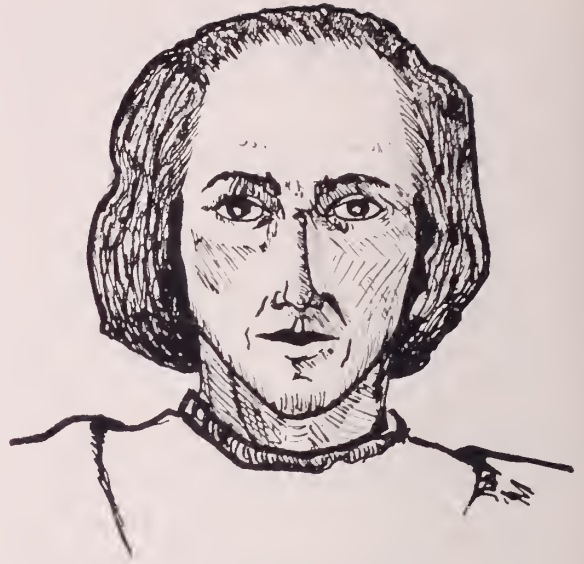


Fig. 5.—This semblance is Master Garcia Fernandez, physician and supply officer for the voyage, who became a close and life-long friend of the Admiral.

pher permission for his Great Enterprise. Santangel presented a strong case against the council and finalized his appeal by relating that there was "so little to risk for so vast a gain." After Santangel's affrontage, the Spanish magistrates made the paramount decision. It is without question that the Queen was very happy about this. Would you believe that she even proposed her crown jewels be sold to defray the expense of the enterprise! This was never necessary. It is said that to outfit the first voyage cost about fifteen thousand dollars, incomparable with explorations today. It is almost inconceivable that the Spanish sovereigns granted every demand the Admiral requested, but this is exactly what transpired.

There were many harbors in southern Spain available for the sea captain's official port of disembarkation. The small harbor of Palos was chosen as the place for outfitting the fleet because there were plenty of sailors available and the village fathers had broken some type of law for which the Queen "conveniently" fined the municipality two fully equipped caravels. There is a third reason which Columbus never discussed in his Journal and this concerned religion.

The Catholic magistrates of Spain were extremely jealous of their own church; namely, the Catholic Apostolic Church. Those who did not

adopt their faith were commanded to leave Spain by August 2, 1492, or be burned at the stake. This included believers of Lutheran, Huguenot and Hebrew religions. The sea captain realized the larger seaports would be an amalgamation of these religious rejects attempting to find voyage to "anywhere;" therefore, he decided to utilize an out-of-the-way port. He also chose to leave on Friday, August the third which would be the day after the departure of the "heretics." In addition to the two caravels that the civic-minded of Palos donated, Columbus chartered a third ship officially named *La Gallega*, but renamed *Santa María* by Columbus after the patron saint of Moguer. This ship met with disaster in the Caribbean Islands. It was the custom for ships to be known by two names, an official one which was usually religious in title, and a nickname. So Columbus' second vessel, *Santa Clara* was nicknamed *Niña* after her builder, Juan Niño of Moguer. Although the *Santa María* was the flagship, the *Niña* was the Admiral's favorite. It travelled about 25,000 miles for the Admiral and has been called "one of the greatest little ships in the world's history." There is less known about the third craft, the *Pinta*, than the other two vessels. When it returned to Spain after the first voyage it became lost between the pages of history. You will be disappointed to learn there are no authentic pictures of these three watercraft and no one actually knows how they looked.

Most of the ships' officers were from Palos and the total known complement of men was eighty-seven in number although some investigators believe there were more. Thirty-nine officers and men were aboard the *Santa María*, twenty-six on the *Pinta* and twenty-two shipped with the *Niña*. You should know that the officers and crew were not a group of criminals pardoned specifically for the Western Enterprise, as some reports would have you think, but were either experienced swash-buckling seamen out for a gain in gold, or young sporting swabs searching for severance from their umbilical cord. The argosy carried an interpreter of languages, a secretary to record officially the discoveries, a royal comptroller and a chief steward. The chief steward was none other than Master García Fernández, who took a sabbatical from his active practice in Huelva to become chief steward and provided the dispensing

of all drugs and dressings. His dispenserio was on the *Pinta* which was logical because the *Santa María* was loaded with flagship materials and the *Niña* was the smallest of the fleet. Each ship in the flotilla was allotted one doctor. Men of medicine were addressed as "Master," a title given to higher educated individuals. Master Juan Sánchez of Cordova was the guild surgeon aboard the flagship *Santa María* and a friend of Beatriz Enríquez, Christopher's mistress. Master Alonso of Moguer was the physician on the *Niña*. He also had been for years the doctor for the Juan Niño family who owned the *Niña*. He was a specialist with the alembic. Master Diego was the barber surgeon aboard the *Pinta* and a close friend of Martín Alonzo Pinzón, Captain of the *Pinta* (fig. 6).

That you may not be deprived of the medical developments necessary in preparing for this sea adventure, let us eavesdrop on our four colleagues during one of the evenings prior to the celebrated departure from Palos. The *Pinta* had no "sick bay" so the medical officers conversed on the fantail. If you listened closely you could hear Master García, the despensero, address his confederates in a low bass voice:

Señors, we all are well acquainted with the inventory of supplies. Our welfare is in the hands of God Almighty and only He knows our destiny. We must dispense the



Fig. 6.—This sketch of the three Columbine physicians is the author's conception of Master Sanchez of the *Santa María*, Master Diego of the *Pinta* and Master Alonso of the *Niña*. Two gave their lives in the discovery of America.

In Diverticulitis...

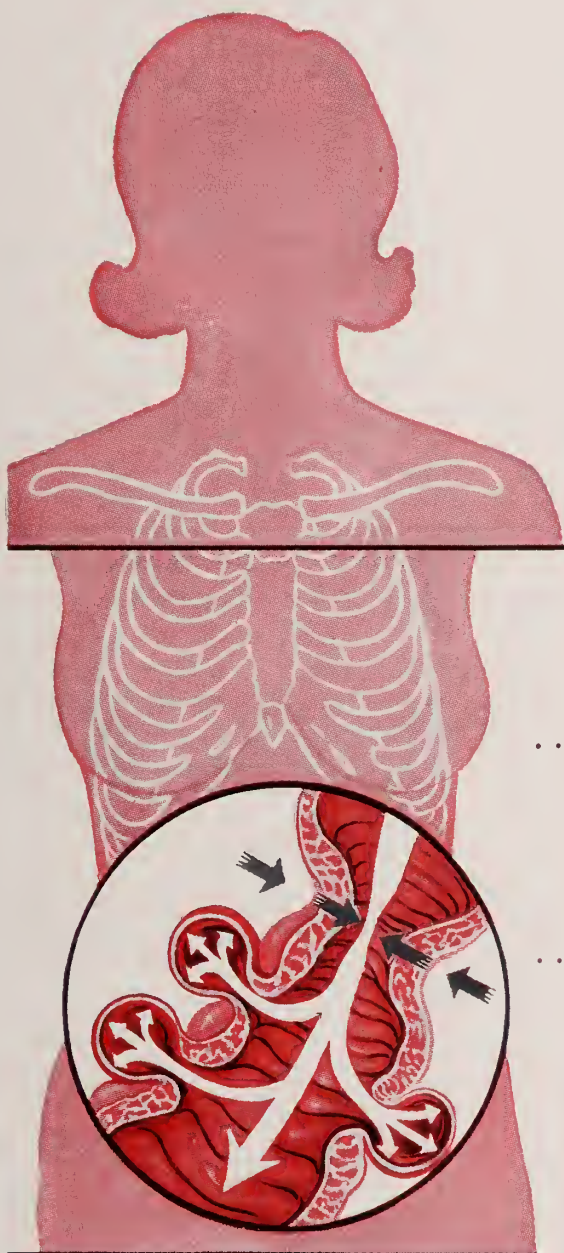
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SEARLE

Research in the Service of Medicine

supplies of aqua, vino and pasto with the adeptness of a madre eagle feeding her infant eaglets. The firewood to feed the galley hearths must be used sparingly. Master Juan, did your deckhands on the Santa Maria ever rummage those confounded rats in the hold below?"

"Well, Amigo, there has been little evidence of rat dung since we swabbed the floor timbers with my new mixture of eucalyptus and pine pitch."

"Master Alonso, on the shakedown cruise you reported the small Niña encountered trouble keeping the bilge water free of a terrific stench. Has this been corrected?"

"No and sí, Master García. No, because we cannot shrink the great waves; hut sí, because the calker installed a larger wooden pump and we have brought more buckets. If those filthy seamen would empty their rectal ampulae into the new rail seats aft instead of the bilge, the odors would be corrected. The tarred rope certainly cleanses the ani satisfactorily and should decrease fistulae."

"Master Diego has enough perros aboard the Pinto to test for poison food. We have extra heating irons for bleeding wounds, olive oil and salt for poultices, licorice root and aromatics for dyspepsias, and aloe leaves for painful muscles and joints. Be sure to run up the apothecary flag on your ship if trouble brews. Well, the evening grows short so let us get some sleep. We will meet again mañana. Buenos noches, caballeros!"

So ends one of the many preparatory medical meetings of our Spanish physicians. Unfortunately Master Sanchez of Cordova and Master Alonso of Moguer, once in the New World, did not live to return home. They volunteered to remain and care for the colonizers who were left at the first New World settlement of Navidad. Presumably they were slain with the others and eaten by the cannibalistic Caribes.

Before sunrise, on Friday, the third day of August in 1492, began one of the most intriguing and important sea voyages ever documented. This same morning the now Captain General Columbus started writing his log which today is known as the *Journal of His First Voyage* or merely "*Journal*." It is by no means an ordinary sea log, but is the anthology of most of our information about the discovery of America. The king and queen received Columbus' original *Journal* as a personal gift by the Adelante when he returned. It is said copies were made and that Bishop Bartolomé Las Casas, the royal historian, and Ferdinand Columbus, son of Christopher, each had one. The original *Journal*, to our knowledge, is lost.

The first landfall after leaving the Mediterranean area was the Canary Islands where the *Pinta*'s damaged rudder was repaired and fresh food materials were brought aboard. Five weeks later on September 6, 1492, the fleet of three small vessels raised their sails and set a direct

course by the Captain General's command, "West, nothing to the north, nothing to the south." The vast stretch of water must have looked mighty lonely to most of the sailors—it was a sea yet to be charted. Columbus had spent many years planning this voyage and his tireless studying began to reap rewards. He depended on what is known in navigation as "DR, or dead reckoning," and this he found by using the three elements; namely, direction, time and distance. The master seaman, deriving direction by the North Star and the Guards of the Little Dipper, directed his three vessels into the velvety northeast wind. The compass, too, assisted in directional estimates. Time was measured at sea by the hourglass. Sea distance could not be accurately measured but was estimated. As Columbus dared not frighten his crews, therefore, he reduced his calculated mileage and circulated the pseudomileage to the sailors. During the latter part of September a sailor on the *Pinta* thought he sighted land. He was so convincing with his gesticulations that the crew, too, imagined they saw the island. Some of the seahands said it looked "exactly" like the pictures of Antillia—the island of folklore. A direct course toward the aqueous mirage for the next eighteen hours was fruitless and it disappeared along with the saddened sailor's hopes.

The three caravels had been sailing a month now on this sea of darkness and over 2,500 miles had been traversed, which, according to their charts, would place them past Japan. The deck hands were exhibiting signs of apprehension while some swabs were even entertaining thoughts of mutiny. The physicians displayed extreme astuteness by practicing their psychiatric versatilities on these careless insubordinates. On the morning of October 7, 1492, the Admiral awoke to see many formations of geese and ducks flying directly west southwest. Although the Captain General was not familiar with this fall migration of birds from Canada to the West Indies, he decided to follow these winged navigators because they seemed to fly aimfully and surely to some land destination. The pilots were ordered to alter their course to west southwest. It was the tenth of October that the crew actually threatened mutiny and told the Captain General to turn back or suffer the consequences. Columbus wrote unconcernedly in his *Journal* that it was useless for

these miserales to complain because he had "signed" commitments to find the Indies and he would not deviate from this responsibility with God's help. The exhausted mariner's conjunctivitis had flared again and Master Juan Sanchez was encountering adversities in quelling the irritation when an omen appeared. The sea presented presumptive symptoms of nearby land in the form of floating tree branches, green leaves, berries and flowers. On the eleventh of October a sailor salvaged from the sea a wood staff which had been carved by hand. Mutterings of mutiny faded from the lips of the men and were replaced by remarks of reward. The Catholic Monarch's award for the first to sight land was the foremost thought in the minds of all—two hundred dollars a year for life!

The crew surmised that this night, October the eleventh, was one of destiny and not a man dared slumber. The hands were fearfully apprehensive and while some searched from the rails, others climbed the rigging expecting to see land any moment. Even the surgeons were exercising their senses. Master Diego had redressed the carpenter's laceration three times that day when once was sufficient. Master Alonso was less nervous, but had erroneously let Ezra, the alcoholic winehead, have a bottle of Madeira when he nearly had him abstained. Master Juan shuffled along at the side of his allergic patient watching his every move. And Master García was the calmest of the group, eyeing his cargo of medical supplies and fermented spirits in case all hell broke loose unexpectedly. The fast Pinta was the lead ship and the lights of the Niña could be seen blinking with every wave just ahead of the Santa Maria. At ten o'clock in the darkness, Columbus and a deckhand saw a light flicker as if it were a candle. The Admiral called consultants, but none could verify it. Was it a fire on shore? Could it have been an Indian fishing? Was land too far away for the light's origin? His palpebral conjunctivitis certainly was not at fault. Historians have made much ado about this light, but actually the controversial incident still remains a mystery. Although the sea was somewhat turbulent, the crews were able to see a long distance in the light of the almost full Autumn moon. The dawn of American history began at two o'clock that morning, the twelfth of October,

1492, when Rodrigo de Triana, the lookout on the agile Pinta, cried out from atop the fore-castle, "Tierra! Tierra!" Addressing Captain Martín Alonso Pinzón, and pointing a trembling index finger toward a white stretch of island, Rodrigo bleated again and again, "Land ho! Land! It is land!" The meritorious occasion was made official when Captain Pinzón fired his ship's cannon, the agreed-upon signal for sighting land.

The two lead ships shortened sail so that the Santa Maria could catch up. Every one of the ninety-some men was now able to see land—The New World! Some sang, some prayed, some wept and some were silent—all discoverers of The New World. The paradoxical Columbus ruled that the 20,000 maravedes, the prize for the first to sight land, was to be purse-stringed by himself and not the Pinta's lookout, Rodrigo de Triana. Ironically, he based this flagrant decision on the presumptive evidence of a light that he personally had seen about four hours previously, but not definitely substantiated by others he consulted. Who dared challenge this Discoverer of The New World!

On October 12, 1492, Columbus found land, but was as lost as a book without a colophon. His title was official now, Admiral of the Ocean Sea, Viceroy and Governor of all the lands he discovered. The pompous Admiral accompanied by his captains went ashore and claimed the land, whatever it may be, by the authority of the Catholic sovereigns of Spain. To this island he gave the name of San Salvador in honor of the Holy Savior. The exact landfall of this great enterprise has remained a mystery for 500 years. Admiral Morison's investigation and recordings in his most informative work "Admiral of the Ocean Sea" proposed the first landing as Watling (Guanahani) Island. A Dutch sea captain, Pieter Verhoog, took issue with this proposal and reported in his 1947 text, "Guanahani Again"⁶ that Columbus' landfall was Caicos.

After resorting to accounts by Morison, Verhoog and others, the unbeatable husband-wife duo, Ed and Marion Link (fig. 7) set out to satisfy their personal emotions as to the Spaniards' first New World landfall. These modern pioneers of underwater archaeology are no Monday morning armchair mariners—and so demonstrated by aero-hedgehopping, as well as reef-running, the contradictory routes of Admiral Columbus. Accom-



Fig. 7.—Marine archaeologists Marion and Ed Link are authors, aero-navigation pioneers and designers of the Link trainer. They retrieved an anchor that possibly belonged to the Santa Maria. These current Columbinees advanced a principled and popular new theory of Columbus' landfall in discovering the New World.

panied by two of the finest shipmates affordable, Captain P. V. H. Weems, navigator emeritus, and Commander Mendel L. Peterson, head curator of Armed Forces History at the U. S. National Museum (fig. 8), the enteric-coated Links on their trawler, the Sea Diver, tracked the "down range" of the Spanish vessels. Not to weary the reader, although the events leading up to the find are quite exciting, this quartet of marine scientists submitted enough syllogism to prove that Columbus made his first boot imprints in the New World on the sands of the Caicos Islands (fig. 9). The Links make believers of you that the Caicos are Christopher's San Salvador, not Watling Island as some think. The Links controversially insist that Columbus saw a light flicker four hours before Rodrigo de Triana sighted San Salvador and they interpolate that this could be definite if the first landfall was Caicos and not Watling. These "Columbine-Linked" explorers are not mistaken in describing their efforts, as they have

retrieved artifacts to "prove their points." Their curiosity has been responsible for the salvaging of pieces of ancient cannon, known as a lombard, used in the time of Columbus' voyage, and an anchor (fig. 10) that measures 78 by 55 inches and fits the proper description of the anchor that the flagship Santa Maria utilized (fig. 11). You will recall that the resting ground of the ill-fated square rigger was in these same waters.

The physicians accompanied the Admiral and the Captains on a two day exploration of the island. Although the naked natives at first would only reveal themselves for fleeting glimpses, they soon became friendly and guided the Spaniards through the island's tropical foliage. Because the land was thought to be a part of India, the explorers called the natives Indians, and to this day all the original red-skinned natives of the Western World, and many of their descendants, are known as Indians. Columbus used a few of the natives from this island as "guides and interpreters" the following three months while sailing among, and naming, the various islands of the Caribbean. He made friends with these innocent tribes of humble and gentle Indians with gifts of beads, trinkets, red caps and hawk's bells. The latter were the most prized by the island's natives. Columbus, as God-fearing and religious as he was, exemplified the thoughts of subsequent conquistadors. He penned in his log, "The natives are in a pristine state of innocence. Women do not wear anything and men do not mind exhibit-



Fig. 8.—Treasure relics from the Old World found in the New World by versatile Dr. Barney and Jane Grile and indispensable Pete Peterson of the Smithsonian Institution.

ing their wives and daughters. How easy it would be to convert these people and make them work for us." From such parables, the Spanish subjects dreamed of the day that they would live in the New World in leisure and without a calloused palm.

Such an era became a near reality during the following fifty years. Hundreds of thousands of Indians, enslaved by the Spanish, were labored to death or killed unreasonably. The Tainos (Arawak tribe) of Hispaniola, under European jurisdiction, decreased from three hundred thousand in 1493 to a mere five hundred in 1540. Nearly the entire population was eradicated, but not without revenge. Through the innocence of the natives and the sexual debauchery of the vagabonds, spirochaete became as prolific in medieval Europe as it

is today among the Arabs. Europe experienced its first epidemic of syphilis in 1494-1496. Those that may doubt the sagacity of these reasonings are referred to Virchow's careful inspections. He maintained that pre-Columbian skulls eliminated the question of prehistoric syphilis in Europe. There is an early book relating that the physicians aboard the two returning ships from the New World treated the sailors for syphilis even before they landed at Palos.

Columbus' rheumatoid arthritis exacerbated while he was cruising among the islands. Master Juan realized that the humid weather may be the etiology. He also knew that Columbus was under strenuous tension searching for the coronary Kublai Khan, proud in his brocade finery and jewels and dwelling in the towered metropolises of

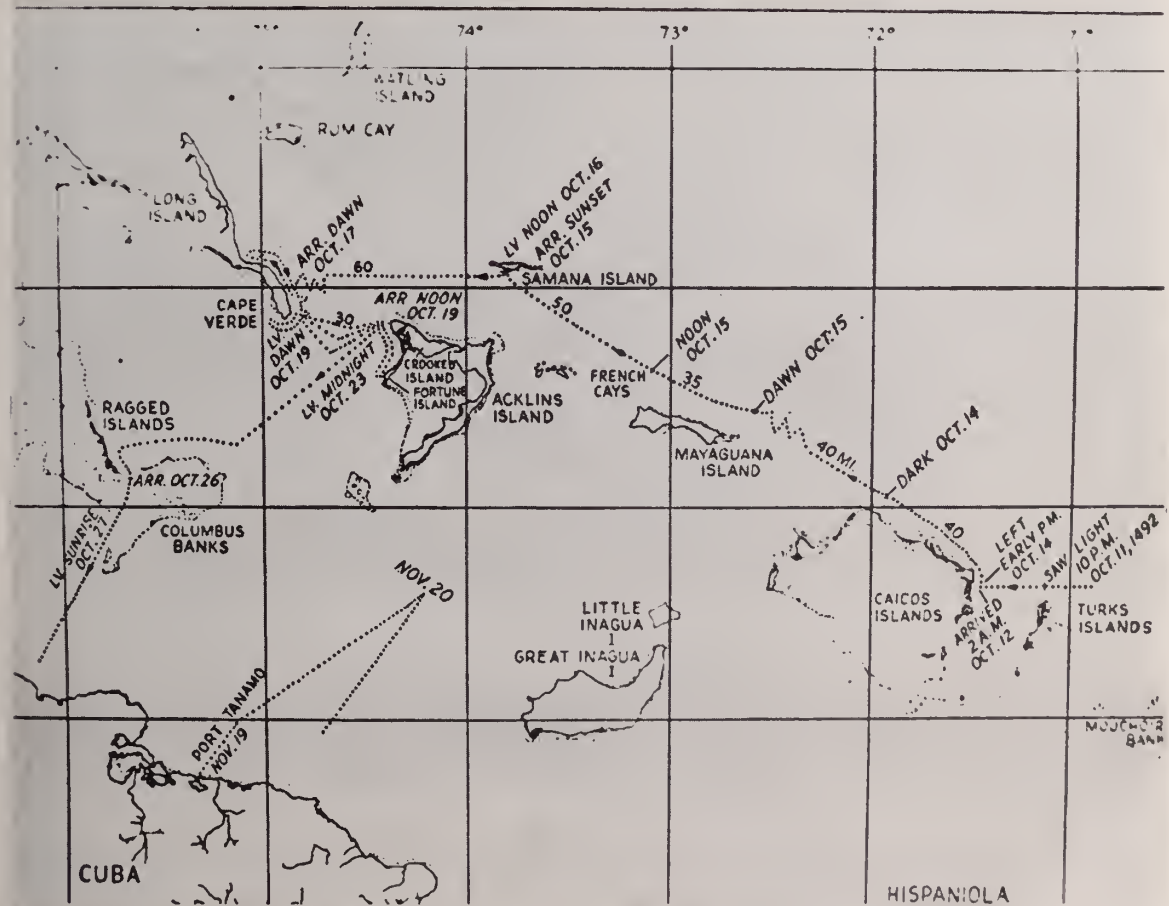


Fig. 9.—The Links carefully followed "directions" from Columbus' Journal and established this version of his first landfall and the voyage through the Bahamas.



Fig. 10.—Ed Link beside the coral-covered anchor that his wife located, and which is believed to have belonged to the hull of the flagship Santa Maria. (Personally furnished by M. L. Peterson)

Cathay with its busy ports. But all the while Christopher's regretful finds were only savage caciques clad in perforated columellas cosmetic with bone spicules and self-inflicted keloidal integuments, living in a jungle parenchyma infiltrated with tortuous mangrove origins and rotund banyans. Tempt and tease as he could with his white magic, he could not prime the red savages as to the whereabouts of the oriental empire that he had so convinced the Catholic Queen was here. The Admiral had now won his titles and privileges, but how long could he keep them without defraying the expense of his voyage with gold and pearls that he had promised by the shipload? Although he exhibited no disappointment in his log briefs, he was obsessed to find the empire, for he could not return without it. He did not locate the precious metals he desired on any of the islands between the Caicos and Watling. The few gold nuggets found in Cuba would not satisfy the Spanish magistrates. It was not until he discovered Hispaniola (Haiti and Dominican Republic) where gold deposits were lucrative, did Columbus dare think of returning home. The Cuillbean cruise

was successful as a trip of discovery; every new island seen was claimed for the Crown and given a name.

Master Juan Sanchez of the Santa Maria, the student of "preventive medicine," was interested in the climate and foliage of the islands. He and Master Diego of the Pinta remained to care for the health of the thirty-seven seamen left to establish a colony in the New World. Master Juan Sanchez examined some roots which the men dug, and reported them to be Chinese rhubarb; this later proved erroneous. The doctors were impressed with the various foods that they were the first to see and examine, such as maize, cassava, chica, sweet potatoes and coconuts. They became the first medicos to examine the herbal leaves that the natives smoked and called tabaca. The Indians were experts in weaving cotton and made swinging beds (hammocks) from this staple. Master García rigged a few of these aboard the Pinta and the sailors appreciated the advantages over sleeping on the filthy deck planks. The doctors were given branches from a tree that made dye and another gum mastic (gumbo-limbo tree). Unfortunately, two of the physicians never returned to Europe to describe the many medical problems they encountered, which would have certainly been an addition to the Journal.

It was on December 24, while enroute to Marien following an all night entertainment by the natives, that the Santa Maria met her fate. The sea breezes were nigh ceased and the Santa Maria and Niña were tacking in Limonade Pass just east of Cape Haitian. The tired seamen were fast asleep, including the helmsman who had turned over the large tiller to a young member of the crew. While the youngster catnapped, the Santa Maria drifted onto a coral reef where she ruptured her hull and began taking on sea water. The crew awakened startled that Christmas morning and at daybreak abandoned ship. Most of the equipment was salvaged with the help of the Indian natives, who tried in vain to move the ship from the coral talons. The Admiral, in a state of divinity, explained to his crew that God had guided them to this spot of reverence to begin a settlement. Because the day was commemorative of the Nativity, Christopher named the village-to-be Villa de la Navidad, or Christmas Town. Thirty-nine explorers, by their own decision, were

left to establish the first Spanish colony in the Western Hemisphere. There were sufficient symptoms of gold ore to entice the men in remaining to "construct their castles, become lords of great estate and mine caches of wealth."

By his charts and computations, the Admiral was convinced he had located the Orient. The seadog had garnered a respectable amount of artifacts, including gold, pearls, and a supply of Indian slaves, that would contest the most doubtful. He caged a flock of parrots which he anticipated using to herald his arrival in Spain. On January 4, 1493, the *Niña* left for home and was joined enroute from the islands by the *Pinta*. The trip east was more hazardous than the trip west in which the ships had encountered tempest weather followed by a hurricane. The *Niña's* sails were torn to pieces and the two caravels became separated. Only due to the superb navigation of Columbus did the *Niña* reach safety into Portugal. After paying his respects to the Portuguese King and Queen and refitting his ship, he sailed for home. On March 15, 1493, the *Niña* moored in the harbor of Palos; her sister ship entered on the same tide—two hundred and twenty-four days after leaving. You have never seen such a bacchanalia to a prodigal son! The barrage of multi-colored, carelessly flying and squawking parrots was a sight to behold. The mariners were acclaimed as heroes and rightly so because they had "found a route to India, China and Japan."

The Admiral had secretly forwarded his official record of the sea journey by royal courier to Ferdinand and Isabella, with copies to Santangel, the royal treasurer, and Beatriz, who along with five year old Ferdinand and the teenager Diego, was anxiously awaiting his return. The always religious Christopher spent the first two weeks with Fray Juan Pérez and his friends at La Rábida. It was on Easter, the seventh day of April, that he received a letter from the Catholic sovereigns. It was addressed to "Don Christobal Colón, Admiral of the Ocean Sea, Viceroy and

Governor of the Indies." The magistrates commanded the Discoverer to attend their court. The letter flattered the man of the sea, but you would never have known it if you had accompanied him entering the regal court that day. Were there any tide of resentment among the nobles, it was buried in a wave of respect to this prototype of King Neptune. The effects of the weather after eight months at sea had coppered his skin, which was most attractively framed by a crown of snow-white hair. The doctor-steward, Master García Fernández, was at court this day, and his emotions were stirred to a sudden state of epiphora when Ferdinand invited his explorer to take a seat beside him on the throne. Christopher had ascended the pedestal—this position of dignity he had so diligently pursued. First the natives of the Indies were presented to the court, and then specimens of gold, island artifacts, pearls, spices, tabaca, cotton-woven hammocks and other New World interests. Following this royal spectacle, there were countless questions from nobles to knaves. Columbus answered each and every interrogator with a canonical adeptness, although he did respond sarcastically to a few, and rightly so. The Admiral enjoyed this day, his day of reckoning. The six natives were under the custody of the two medical men, and after a limited talk with the court physicians, they begged departure with their red friends for less urban relations.

This recapitulation of medical history should be more than a vignette of four Columbine physicians, as the exploits of these personages are deserving of more. Another visit to the Iberian Peninsula and further perusal of the Archivo de Indias at Seville may replete the needed chyle for further intestinal fortitude and assimilation of historical manna. So concludes the physician's memorabilia of the First Crossing in 1492. God is in His Heaven.

References are available from the author upon request.

►Dr. Snyder, 214 Alhambra Circle, Coral Gables 33134.

FREE BILL:

ADOPTED BY THE

PHYSICIANS OF JEFFERSON COUNTY,

JANUARY 1, 1858.

ORDINARY SERVICES:

	DOLLS.	CTS.		DOLLS.	CTS.
Mileage in the day, per mile,	50		Obstetrical Cases, Natural Labor—Whites,	10 to 20	00
" " night, "	1 00		" " " Blacks,	10 00	
Visit in the day,	1 00		Delivering with Forceps,	15 to 25	00
" " night,	2 00		" Placenta,	5 to 10	00
Prescription in office,	1 00		Examination per Vaginum,	2 to 5	00
" " the country, single case,	50		" " " with Speculum,	5 00	
(If a number of cases on the same place, discretion . . .)			(After the first examination, the amount charged, discretionary.)		
Attention per hour after first hour 50 cts. to \$2			Cupping,	1 to 3	00
Consultation,			Bleeding,	1 00	
Letter of Directions,	8 00		Extracting Tooth,	1 00	
Administering Emema,	1 00		Lancing Gums,	1 00	
Applying Galvanic Battery,	1 00		Dressing Wounds,	1 to 10	00
	1 to 3 00		Vaccinating,	1 00	

EXTRAORDINARY SERVICES.

	DOLLS.	CTS.		DOLLS.	CTS.
Reducing Dislocated Shoulder,	10 to 20	00	Extirpating Tumors, in general,	5 to 20	00
" " Elbow,	10 to 15	00	Lancing Abscess or Bone Felon,	1 00	
" " Wrist,	10 00		Operation for Lithotomy,	50 to 100	00
" " Thumb or Finger,	5 00		" " Strangulated Hernia,	20 to 40	00
" " Thigh,	20 to 40	00	" " Aneurism,	20 to 50	00
" " Knee or Ankle,	15 to 25	00	" " Cataract,	20 to 40	00
" " Toe,	5 00		" " Club Foot,	15 to 25	00
" " Jaw,	5 to 10	00	" " Fistula Lachrymalis,	10 to 20	00

Amputating at Shoulder Joint,	30 to 50.00	"	Trochapsus Ani,	5.00
" Arm or Fore-arm,	20 to 30.00	"	Trephining,	30 to 50.00
" at Wrist Joint,	10 to 20.00	"	Embryotomy or Craniotomy,	10 to 25.00
" Metacarpal Bone,	5 to 10.00	"	Removing foreign bodies from Oesophagus,	5 to 10.00
" Finger or Thumb,	5.00	"	" Tonilla,	5 to 10.00
" Penis,	10.00	"	Ligating Arteries,	5 to 20.00
" at Hip Joint,	50 to 75.00	"	Introducing Catheter,	1 to 5.00
" at Knee Joint,	20 to 40.00	"	" Scrotum,	1.00
" Thigh or Leg,	20 to 60.00	"	Dividing Imperforate Hymen,	1 to 5.00
" Foot & Toe,	5 to 15.00	"	" Frenum Linguae,	1.00
Extirpating Breast,	20 to 30.00	"	Arteriotomy,	2.00
" Testicle,	20.00	"		

MEDICINE.

Pills or Powders (when prescribed), per dozen,	25 to 50 cents.
Tinctures,	per oz., 25 to 50 "
Blisters, each,	" 25 to 100 "

We, the undersigned, Practicing Physicians, do adopt the above as our *minimum* rates of charging, and pledge ourselves to adhere to it in all cases, except in chronic diseases, or where persons are in indigent circumstances, when a reasonable discretion will be observed.

R. K. DIXON, J. L. GRIFFIN, A. S. PUGGLESLEY,
 MILLER & POWELL, J. M. OSLIN, J. N. OLIPHANT,
 HUNTER & GAMBLE, A. F. VERDERY, T. M. BOSTICK,
 J. S. BELL, R. A. GARVIN, WM. A. SPEIR,
 R. J. BARTON.

We, the undersigned, Practitioners of Medicine, in Burke and Washington counties, pledge ourselves to conform to the Jefferson County Fee Bill, as far as our practice and intercourse with the Physicians in that county are concerned.

W. C. MUSCHROVE, L. J. K. KILPATRICK, THOS. BURDELL,
 THOS. CHEATHAM, WILSON, PRYOR.

THE BILL

Adopted by the Physicians of Louisville, January 1, 1858.

Visits and Prescription per day, (ordinary attention,)	\$1.50
" " " (extra attention,)	2.50
" from bed at night,	2.00

We, the undersigned, Practicing Physicians, do adopt the above as our *minimum* rates of charging in all cases, unless in those exceptions specified in the general Fee Bill of the county.

R. K. DIXON, MILLER & POWELL, HUNTER & GAMBLE, R. A. GARVIN.

JEREMIAH MORRIS, PRINTER—AUGUSTA, GA.

A Doctor and a Rascal

From an early period of its development, Tampa has been a very cosmopolitan community, including in its population people from practically every country on earth. Among these probably the most picturesque was Dr. Frederick N. Weightnovel, a Russian. He was a self-confessed nihilist and had been banished to Siberia by the czar's government then in control of Russia. He escaped from Siberia by swimming a great distance to another country. Weightnovel was a remarkable specimen of physical development. He wore his hair long—hanging down on his shoulders—and his chest expansion was tremendous.

When the Atlantic Coast Line completed the docks at Port Tampa a popular feature of amusement was the Sunday afternoon excursion to the port to see the ship from Havana land and to Picnic Island, an embryo Coney Island south of the docks developed by the railroad company. Weightnovel was usually among the pleasure-seeking throngs on these trips, and nearly every Sunday afternoon he gave a free exhibition of his ability and endurance as a swimmer. He would float on his back and eat his dinner from a plate placed on his chest, and after his dinner would smoke a cigarette and read a newspaper—even in rough water. He manufactured and peddled a hair tonic, picturing on the label his own heavy growth as an example of the crop his tonic would produce.

When the old military reservation known as Fort Brooke—the territory south of Whiting street to the bay front—was abandoned by the war department and transferred to the interior department in 1883, it was soon thereafter thrown open to homestead. A number of "squatters" had settled in the reservation even before the soldiers were shipped out, but when the proclamation was issued opening the land to homesteaders there was a great rush to secure parcels of the valuable property. Among the horde was Dr. Weightnovel, who took with him a group of loafers and bums. They erected several shanties and attempted to incorporate a town under the name of Moscow.

Anticipating trouble, Weightnovel had equipped his "army" with such weapons as he could secure, and for a few days Moscow was under siege. However, the Russian and his followers were ousted without bloodshed when he was convinced that he could not maintain a claim to the property—I do not think he even attempted to become a naturalized citizen.

But the most notorious incident of Weightnovel's career in Tampa—and the most widely publicized—was a parade and banquet of a "Free Love" society which he had organized, composed largely of young men of questionable character. The parade was held in the morning on Seventh avenue, from Twenty-second street to Nebraska avenue. The Russian led the parade. They were mounted on horses and all wore broad white ribbon sashes on which the name of the society was printed in large gilt letters. The crowds on the street jeered the paraders, as the disreputable character of the members was generally known. After the parade the society had a banquet in the large dining hall of the old Hotel Habana on Seventh avenue. The windows of the dining hall extended to the floor, so that people in the street had full view of the interior, and the spectacle presented in the hall caused a great crowd to assemble—the waitresses were negro women, and all were entirely nude. The place was raided by the police and sheriff's deputies before the members of the society had consumed much of the food, and many of them were hauled off to jail. That was the end of Weightnovel's free love society.

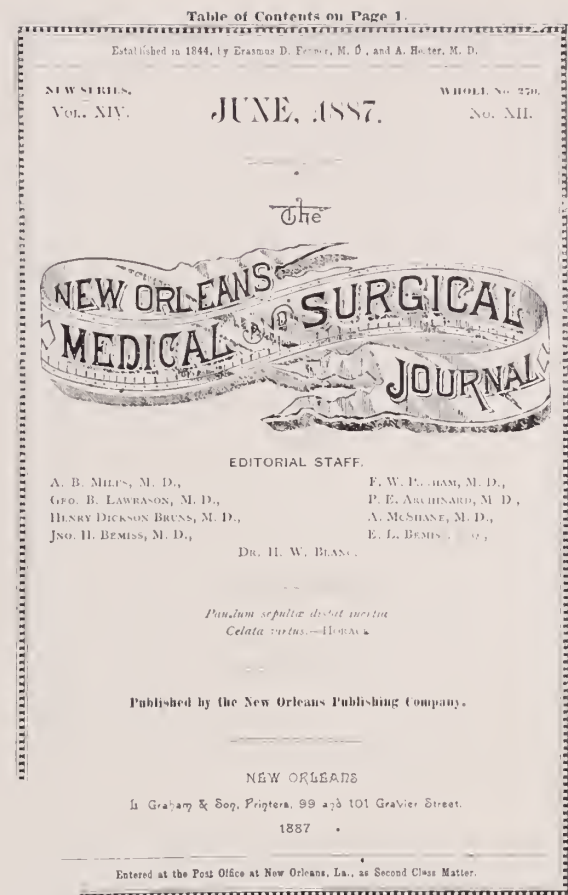
The last years of his time in Tampa, Weightnovel operated a "hospital" in a two-story building on Whiting street between Franklin and Tampa. The general belief was that his principal business was the performance of abortions. Finally a young woman died in the place as a result of an illegal operation. The place was raided by the sheriff and on evidence discovered Weightnovel was indicted by the grand jury. Shortly thereafter he died. It was the general belief that he poisoned himself.

Meeting of the Florida Medical Association St. Augustine May 17-19, 1887

I do not know how I could more appropriately begin my Florida notes than with the chaste and elegant exordium of Dr. C. H. Mallett, whose admirable report of the proceedings of the 13th annual session of the Florida Medical Association appeared in the columns of the *Morning News* of Jacksonville.

Just once a year the Doctor's worthy dame
Goes to the barn and shouts her husband's name,
"Come, Rip Van Winkle!" (giving him a shake)
"Rip! Rip Van Winkle! time for you to wake!
Laylocks in blossom! 'tis the month of May —
The Doctor's meeting is this blessed day,
And come what will, you know I heard you swear
You'd never miss it, but be always there!"

The year 1874 saw the first meeting of the physicians of Florida, assembled in convention to discuss matters pertaining to their profession and to adopt a code for the better guidance of their mutual relations. This resulted in the formation of the Florida Medical Association, which has since then met regularly every year, each meeting showing an increase of membership and a more wide-spread interest in the work of the Association. It has come to be regarded as one of the most useful institutions in the State; it represents the best element in the medical profession in Florida; it has already brought about many reforms and has accomplished much which the general public is not quick to recognize, but the lasting results of which will be seen in years to come. It is a hard working body of earnest men—each in love with his profession and his life work—men who do not meet to have a good time, but to devote the brief respite allowed by the



confining nature of their calling, to furthering the interests of the people among whom their lot is cast. That the Association is growing in numbers and influence is attested by the large attendance at St. Augustine yesterday as well as by the numerous applications for membership.

There were about forty members in attendance, and there was a spirit and an energy of feeling pervading the whole meeting which promised much for the future interests of medicine in our great sanitary peninsula. It is needless to say that the Association was royally received. St. Augustine, with its archaic structures and classic memories, has been too long the Mecca where all pilgrim footsteps travel to be wanting in aught that pertains to the comfort or the pleasure of all who come within her ancient walls.

The President of the Association, Dr. J. V. Porter, of Key West, delivered a most admirable inaugural address, a few extracts from which will.

as old Samuel Pepys would say, prove "*monstrous good reading*." Dr. Porter introduced his address with the following very satisfactory remarks:

Gentlemen of the State Medical Association of Florida—

"As I rise to greet you, I see before me representatives of our noble profession from the various sections of the State assembled together to-day in the common cause of philanthropy and humanity. To each and all of you it gives me pleasure to bid you a cordial welcome, trusting that this thirteenth annual meeting of the Association may be one of the most interesting and profitable in its history.

"In the exercise of my duties as presiding officer during the past year, I have been called upon to make no decisions, and therefore conclude with much satisfaction and pride that the utmost harmony prevails in the different county and local societies of the State. It is with devout thankfulness that I announce that our State has been spared during the past year any epidemic and that we have not the history of any serious sickness to speak of or discuss."

After eloquently and tenderly referring to those who had fallen in the ranks of the profession during the past year, he proceeded to take up the great question of the hour—the organization of medical authority in the State by proper legislative enactments. I am sure that the extracts which follow will be interesting to all who have the great interest of State medicine at heart:

"Although this is the first time the Association has met in St. Augustine, there seems to me a peculiar appropriateness in our gathering here. For it was at this place, we are told, and at this season of the year, that the gallant Ponce de Leon, three centuries ago, first landed in his romantic search for the fountain of health in the Land of Flowers. It is, therefore, fitting that we who are endeavoring to discover and point out the way of health should discuss on this historic spot the most rational means of bringing about that ideal state of public well-being which all men desire. And I cannot help feeling that a peculiar responsibility rests upon the physicians of Florida. While there are now no Ponce de Leons eagerly looking for the impossible, our State is nevertheless the Mecca of many thousands who hope to find in its balmy atmosphere a complete restora-

tion to the health they have lost, or at least a respite from their suffering.

"Florida is unquestionably the hope, and so far as one State well can be, the future home of many of the invalids of this great country. It is easy to see that with the usual character of this immigration, coupled with the fact that the comparatively recent development of "opening up" of the State has given us a strikingly heterogeneous population, the physicians have before them a task of unusual magnitude and difficulty to adequately instruct, direct and care for the people. The obligations imposed upon us as conservators of the public health are too well understood and appreciated by all of us, I am sure, to require emphasis at my hands."

* * * * *

"It is not alone upon domestic hygiene and sanitation that the future prosperity of our State depends. Possessing, as it does, an immense sea coast, with fine harbors and many navigable inlets, it is the more important that a system of quarantine should be perfected and enforced that will, during the summer, or when sickness prevails as an epidemic elsewhere about the globe, protect our sea coast cities from the introduction of pestilence. While I believe in stronger measures, I believe also in intelligent ones, and I would abolish the term quarantine, which savors of centuries of superstition and darkness, and substitute therefor "maritime sanitation," as suggested by an able surgeon of New Orleans. I have faith in a system that will hamper commerce and travel as lightly as is consistent with true protection. I would insist upon this protection, and I would make it so certain that it would be as infallible in its method of procedure and ultimate action as anything human can be; but with stringency I would have intelligence and ability. Such a system, I claim, our State has been the first to inaugurate, by which uninterrupted communication can be had with a foreign port, the native habitat of one of the most pestilential diseases, and at the same time have that disease effectually excluded from our coast. What was an experiment, looked upon with distrust two years ago, now has the unbounded confidence of our sea coast cities. The only danger to the system is one of relaxing vigilance, and as eternal vigilance is said to be the

price of liberty we can appropriately paraphrase the saying in this instance as being the eternal price of health and happiness.

"To those of you who will soon be called upon to exercise authority in the State Health Association, I would especially invite attention to the imperative necessity of immediately securing an enactment that shall effectively suppress the charlatanism which is peculiarly a curse to Florida on account of the ignorance and superstition of its negro, and a considerable portion of its white population. The audacity and impudence of some of the itinerant quacks who infest the State, especially during the winter, are simply amazing. It is not alone the harm they do by wheedling the last dollar from the pockets of poor people, giving them worthless nostrums in return, that warrants legal interference, but their unconscionable denunciation of the regular physicians and their methods, thus off-setting and making invalid much of our best work among the masses. We need a law for the suppression of charlatanism more for the protection of the masses than of the physicians, for the people are the chief sufferers. And this desirable law, while sufficiently exacting and severe to suppress the dangerous quacks referred to, need not exclude from practice those men of education and professional attainment who, through some whim, choose to array themselves among the "pathies," as it has unjustly done in other States. We need not surrender any of our traditions or beliefs of purposes while bearing a liberal attitude toward honest men whose views, as physicians, may differ in minor details from ours. To practice medicine in this State or elsewhere, the person should be a gentleman or lady in the strictest sense of the term, and should possess a thorough knowledge of the fundamentals of medicine, together with a liberal education otherwise. With these requirements fulfilled and substantiated by a board, I would permit him or her to practice medicine, irrespective of the terms they choose to apply to themselves. More is to be gained, it seems to me, by cordial co-operation with intelligent, educated and sincere "dissenters," if I may borrow the term, than by a continuance of the antagonism which has so long characterized the relations of the schools, so called, of medicine. Let us take pains to make it understood that we hold these liberal views, accepting what is good

and true, no matter where we find it, and the good feeling and co-operation which will follow more than compensate for what may appear an unbending from our hitherto "close-communion" position. Our Association should be broad and liberal enough to be above differences and dissensions that a little frank and good-natured discussion may reconcile or dissipate. It frequently happens that men who suppose themselves hopelessly opposed to each other with regard to certain principles or views, find, upon comparing notes, that in reality they can work harmoniously together for the attainment of a common end.

"Our work as public sanitists ought to be easier in the future than it has been in the past, for there is now a general recognition of the fact that many diseases are preventable—whereas there was a time when all diseases were considered a direct visitation of Providence—that there is a growing feeling among the people that scientists are able, through chemistry and the microscope, to discover impurities in food and water, and that therefore men who make a specialty of scientific sanitation and investigation ought to be competent to discover and avert causes of disease. I repeat, that there is a growing appreciation of these things, and the fact ought to encourage as well as help us. If we but do our part untiringly and heartily, we shall soon gather the beneficent fruit of our labor."

Among the most interesting papers presented were those of:

DR. C. J. KENWORTHY, on *Basilar Meningitis*, offering as a pathognomonic diagnostic sign the excruciating agony produced by a *contre-coup* on the vertex, referable to the base of the brain.

DR. J. D. FERNANDEZ, on *Retention of Urine*. The paper was a strong *apology* for the urethrotome.

DR. F. F. SMITH, on the *Climate of St. Augustine in Summer*. A very valuable statistical paper, which showed close and accurate observation and elicited animated discussion.

DR. DEWITT WEBB, on *The Indian under Medical Observation*.

DR. C. H. MALLETT, on *Antifebrin*.

Many of the papers would do credit even to an assembly of doctors in *Jerusalem*, though they may and do think that "no good can come out of Nazareth."

The annual oration was delivered by Dr. Neal Mitchell, of Jacksonville—an ornate production as polished as his personnel, and as graceful as his delivery.

The "Hamlet of the play," however was Dr. Pelot's bill sent to the Association from the Legislature now in session for amendment and endorsement. After a free discussion it was enthusiastically sent up to the Legislature, with the prayer for its success before a body that has hitherto put the heel of disfavor upon every effort to elevate the profession to its proper plane of dignity, respectability and power in the commonwealth of Florida. So important is this bill and of such general interest to the profession, at large, that I think it should appear in full. The following is the bill as amended and endorsed by the Association. (Bill omitted)

PERSONAL.

It gave us peculiar pleasure to meet the venerable DR. A. S. BALDWIN, the Nestor of Florida medicine and the father of the State Association, which assembled in his office for the first time.

Dr. BALDWIN's presence falls ever like a benediction upon the annual gathering of Florida doctors. The genial old gentleman has lived in Jacksonville since 1838. He is a graduate of the old Geneva school and an honored contemporary and personal friend of those grand old men whose names we shall ever delight to honor, but whose forms are seen among our assemblies no more. God bless our veteran doctors! May the day long be distant when we shall forget to honor them in our councils and to be faithful to the glorious heritage which they have bequeathed us.

THE NEW ORLEANS MEDICAL AND SURGICAL JOURNAL.

The announcement of the amalgamation of the Florida Medical and Surgical Journal with the NEW ORLEANS JOURNAL was most favorably received and the profession of the State have assured me of their renewed interest in Southern journalism and of material support of the organ which is so admirably adapted to the present needs of the Association. Copies of the April and May numbers were distributed and eagerly appropriated.

T. O. S.

Reprinted from New Orleans Medical and Surgical Journal, Vol. XIV, No. XIV, June, 1887

Member of the American Medical College Association.

Medical and Dental Departments

OF THE

UNIVERSITY OF TENNESSEE,

Nashville Medical College,

Broad Street, bet. Vine and High.

FACULTY:

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WILLIAM P. JONES, M.D., PRESIDENT OF THE FACULTY.	
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WILLIAM P. JONES, M.D., Professor of Surgery and Principles of Surgery.	WM. G. BRIEN, M.D., LL.D., Professor of Medical Jurisprudence.
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J. BRYAN STEPHENS, M.D., Professor of Obstetrics and Gynecology.	ROBERT RUSSELL, M.D., D.D.S., Executive Professor of Operative and Mechanical Dentistry.
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PAUL F. EVE, M.D., Professor of General, Descriptive and Surgical Anatomy.	JAMES M. GLENN, D.D.S., Demonstrator of Operative and Mechanical Dentistry.
	ROBT. F. BURNS, D.D.S., Demonstrator of Operative and Mechanical Dentistry.

The Faculty Session Commences on Monday, October 4, 1886, and continues until the last Friday of February, 1887, when it commences next day.

CLINICAL ADVANTAGES.

The University of Tennessee, which is located in the largest possible extent in the city of Nashville, Tenn., is the Medical Department of the University of Tennessee. For the purpose of the University since the last session of the College has been held in the rooms of the ground floor of the College building by order of the Medical Faculty of Nashville, a savings of between 2,000 and 3,000 prescriptions has been effected for the indigent poor of the city, since this important change has been made.

During the session members of the Faculty will be in attendance daily, in order to prescribe for all who may apply, in the presence of the class; thus affording one of the most efficient and instructive methods of teaching in America.

Students desiring further information, should address the Dean, and give in their communications their name, address, and State.


For information, address
DUNCAN EVE, M. D.,
DEAN OF THE FACULTY,
Nashville, Tenn.

Reprinted from the Alabama Medical and Surgical Journal, September, 1886.

756

SOMETHING NEW

THE NEATEST,
THE LIGHTEST,
THE STRONGEST,
THE MOST CONVENIENT.



PRICES.

Black Leather.		Black Russet Leather.	
No. 1 contains 16-1/2 lbs.	\$10 00	No. 1 contains 16-1/2 lbs.	\$12 00
No. 2 contains 18-1/2 lbs.	11 00	No. 2 contains 18-1/2 lbs.	13 00
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The above cut represents the Stephens' patent Saddle Bags, the most compact strong, and only entirely water-proof bag made.

GEO. K. HOPKINS & CO., Wholesale Druggists,
Sole Agents for the United States and Canada,
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Kept in stock by T. L. LYONS & Co., New Orleans, La.

Reprinted from the New Orleans Medical and Surgical Journal, June, 1887.

President's Page



The Challenge

The thoughts and material appearing on this page are those of your President. There is nothing official about these reflections as far as FMA is concerned unless it is so stated. I mention this mainly to assume all responsibility as far as any criticism or agreement is concerned. My role is to represent FMA and to carry out its programs and philosophy as determined by the House of Delegates and Board of Governors. Your officers and administrative staff desire constructive criticism and suggestions. Progress and accomplishment of goals require a positive and dynamic action, not a negative one.

This page is written several weeks before publication; therefore, one has to try to think ahead and prognosticate and fit into the situation as well as he can. It is now late June at this writing. We all know that the initial phase of a major change in the practice of medicine will have begun on July 1. By the time this is read many questions, problems, apprehensions, frustrations and disagreements will have occurred.

Let us hope that our profession will have continued its main function in an honorable and ethical manner according to our tradition. If those in government and bureaucracy have not done the same, then we should do all in our power to expose this subversion and circumvention of PL 89-97 and rectify the situation. We must clearly point out the danger and place the blame where it properly belongs, namely on rigid, uncompromising, illogical rules and regulations made by administrators with gun-barrel vision circumventing the intent of the law as originally meant by the Congress. We must not allow our profession to be the scapegoat if the program does not go well—and it won't, because history has already shown this in every other country in which government has taken over financing and administration of medical practice.

Criticism and disagreement are only negative unless we have something better to offer. Our legislators and administrators will listen if we remain firm, resolute and constructive. Being just against something has been for naught as we all sadly reflect.

Spirits are not finely touched
But to fine issues.
Our doubts are traitors
And make us lose the good we oft might win
By fearing to attempt.

"Measure For Measure," William Shakespeare

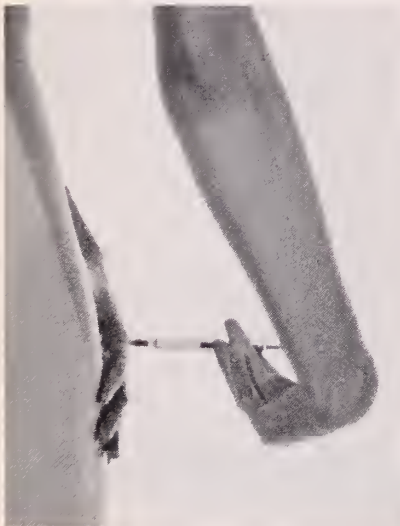
George S. Palmer

New low-cost tetracycline/antifungal therapy

for broad-spectrum activity
plus specific antifungal prophylaxis
at significant patient savings

Whenever tetracycline is indicated in these candidates for Candida

1. diabetic patients



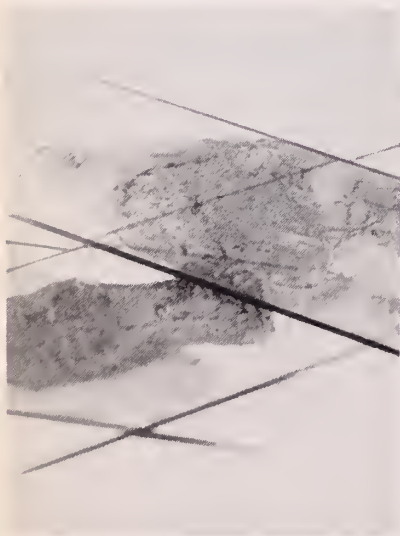
2. nonpregnant women with a history of recent
or recurrent monilial vaginitis



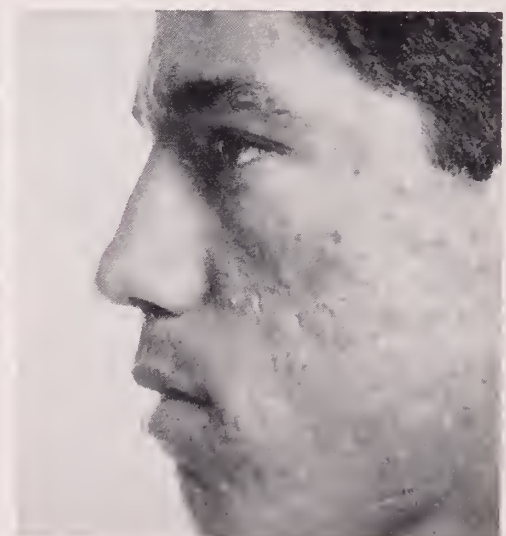
3. elderly or debilitated patients



4. patients with a past history of moniliasis



5. patients on long-term tetracycline or cortico-
steroid therapy



BRISTOL THERAPEUTIC SUMMARY: For complete information consult Official Package Circular. **Indications:** Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. **Contraindications:** The drug is contraindicated in patients hypersensitive to its components. **Warnings:** Photodynamic reactions have been produced with tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discoloration occurs. No cases of photosensitivity have been reported with Tetrex (tetracycline phosphate complex). With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. **Precautions:** Staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). **Precautions:** Bacterial superinfection may occur. Infants may develop increased intracranial pressure with bulging fontanelles. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. **Adverse Reactions:** Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. **Usual Dosage:** 1 capsule *q.i.d.* Continue therapy for 10 days in beta-hemolytic streptococcal infections. Administer 1 hour before or 2 hours after meals. **Supply:** Capsules, bottles of 16. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl and 250,000 units of nystatin.

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York

Tetrex-F®

Each capsule contains tetracycline phosphate complex equivalent to tetracycline hydrochloride 250 mg. and nystatin 250,000 units.

Tetrex-F is priced lower
than most
tetracycline-antifungal products.

Doctor,

Here is the Abbott anorectic program designed to meet the individual needs of your overweight patients.



mood elevation

Abbot
Anorectic
Program

DESOXYN® Gradumet® (methamphetamine hydrochloride)

Smooth appetite control plus mood elevation.

The obese patient on a diet often has to battle depression as well as overweight. Desoxyn Gradumet helps the dieter in both battles by elevating the mood while it curbs the appetite. Thanks to the Gradumet, medication is smoothly released all-day from a single oral dose.

If she can't take plain amphetamine, put her on **DESBUTAL® Gradumet**

Calms anxieties; controls compulsive eating.

Desbutal Gradumet provides 2 drugs in 2 tablet sections, combined back to back to form a single tablet. One section contains Desoxyn to curb the appetite and lift the mood; the other contains Nembutal® (pentobarbital) to calm the patient and counteract any excessive stimulation.

Both drugs are released in an effective dosage ratio throughout the day.



controlled release

Abbott
Anorectic
Program

Not all long-release vehicles are the same. Here is why the Gradumet is different and what it means for your overweight patients.



The release action is purely physical and relies on only one factor common to every patient: gastrointestinal fluid. There is no dependence on enteric coatings, enzymes, motility, or an "ideal" ion concentration in the gastrointestinal tract.

Your patients get a measured amount of medication, moment by moment, throughout the day.

They are not subjected to ups and downs of drug release . . . or to erratic release from patient to patient . . . or to erratic release in the same patient from day to day.

That's why the Gradumet provides controlled-release as well as long release.



Perhaps you saw the Gradumet model demonstration which shows that the release is entirely physical. When fluid is added, the drug in the outer ends of the channels dissolves. As fluid penetrates deeper into the channels, there is a continuous release of medication. The rate of release is rigidly controlled by the size and number of channels.

choice of 5 strengths

Abbott
Anorectic
Program

DESOXYN Gradumet

Methamphetamine Hydrochloride in Long-Release Dose Form



5 mg.



10 mg.



15 mg.

DESBUTAL 10 Gradumet

10 mg. Methamphetamine Hydrochloride,
60 mg. Pentobarbital Sodium



Front



Side

DESBUTAL 15 Gradumet

15 mg. Methamphetamine Hydrochloride,
90 mg. Pentobarbital Sodium



Front



Side

samples available



Each sample contains 6 tablets and a filled Sucaryl® Sweetener dispenser. For a supply, write Abbott Laboratories or ask your Abbott man.

Desbutal 15 Gradumet

Product of choice for patients who overreact to plain amphetamine

As an anorectic in treatment of obesity, also to counteract anxiety and mild depression. Desbutal is contraindicated in patients taking a monoamine oxidase inhibitor. Nervousness or excessive sedation have occasionally been observed; often these effects will disappear after a few days. Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism or who are sensitive to sympathomimetic drugs. Careful supervision is advisable with maladjusted individuals. A single Gradumet tablet in the morning provides all-day appetite control. Desbutal 10 contains 10 mg. of methamphetamine hydrochloride and 60 mg. of pentobarbital sodium. Desbutal 15 contains 15 mg. of methamphetamine hydrochloride and 90 mg. of pentobarbital sodium in bottles of 100 and 500.



Sucaryl Sweeteners

A proven aid to weight control—

For use in beverages and foods—stable to heat

A constant reminder to your patient to "watch her calories"

A carefully balanced formula to prevent aftertaste

—in tablets and liquid—

Sucaryl—Abbott brand of low and non-caloric sweeteners

Press out tablets from this side

LOT NO. 784 1231



For:

Directions:

Or:



economy

Patients, in many cases, save enough to get five weeks of medication for the price of our, compared to other leading long-release anorectics.

CONTRAINDICATION: Desoxyn and Desbutal are contraindicated in patients taking a monoamine oxidase inhibitor.

PRECAUTIONS: Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs or ephedrine and its derivatives. Careful supervision is advisable with maladjusted individuals.



Gradumet—long-release dose form, Abbott: U.S. Pat. No. 2,987,44
Sucaryl—Abbott brand of low and non-caloric sweeteners.



The Medical Detective

The Journal this month inaugurates a new feature entitled "The Medical Detective," by William G. Eckert, M.D., an Orlando pathologist experienced in forensic medicine. Dr. Eckert will be assisted from time to time by guest contributors.

The objective of "The Medical Detective" is to bring firsthand information to the physicians of Florida about various forensic problems peculiar to our state, and additional information about forensic problems in other parts of the country. This will be accomplished through illustrative cases and general discussion of the problems.


Forensic problems involve cases in which there is a broad possibility of legal complication. This applies to problems relating to accidents, suicides, homicides, industrial hazards, environmental hazards, dangerous animals and plants, poisonings, complications of medical care and treatment and various problems of liability. It is hoped this feature will bring out an awareness of the value and necessity of adequate medico-legal investigation being made available to all of Florida's citizens.

Medico-legal investigation refers to the investigation of certain deaths by physicians who have special training in forensic medicine. These are usually pathologists working in a formal system of medico-legal investigation known as a Medical Examiner system.

The Medical Examiner system differs from the Coroner system in that it is not an elective office and involves trained physicians. Deaths coming under jurisdiction of a Medical Examiner system include all unnatural and unexpected deaths in persons not under a physician's care. These are investigated and reports made out. The reports are recorded and become public record. Investigation may include on the scene inspection, autopsy if necessary, and possibly toxicologic examinations. Thus, every person meeting violent death will have a blood alcohol examination, and persons who commit suicide due to drugs will have a toxicologic examination.

We sincerely hope this feature provides an educational tool for the physicians of our state and thereby benefits their patients. Any suggestions and inquiries on cases discussed, or on other forensic problems, will be welcomed and appreciated.

T.M.



must penicillin
be a bitter pill
to swallow?

not if it is
V-Cillin K.

V-Cillin K now has a unique glossy coating that banishes bitter penicillin taste and makes it easier to swallow. Within six seconds (just long enough for the tablet to get past the taste buds), the coating dissolves and the penicillin is ready for immediate absorption into the bloodstream. The patient still gets all the special benefits of V-Cillin K, including consistent dependability . . . even in the presence of food.

Indications: V-Cillin K is an antibiotic useful in the treatment of infections caused by streptococci, pneumococci, and sensitive strains of staphylococci.

Contraindications and Precautions: Although sensitivity reactions are much less common after oral than after parenteral administration, V-Cillin K should not be administered to patients with a history of allergy

to penicillin. As with any antibiotic, observation for overgrowth of nonsusceptible organisms during treatment is important.

Usual Dosage Range: 125 mg. (200,000 units) three times a day to 250 mg. every four hours.

Supplied: Tablets V-Cillin K, 125 or 250 mg.; also, V-Cillin K, Pediatric, 125 mg. per 5-cc. teaspoonful, in 40, 80, and 150-cc.-size packages.

V-Cillin K[®] Six-Second
Barrier to
Bitterness
**Potassium Phenoxymethyl
Penicillin**

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

Lilly

Behind continued high blood pressure readings lies the possibility of organic damage¹⁻¹³

MANY OF THE aspects of essential hypertension are unpredictable—either because there are a number of mechanisms involved or because individuals differ in their responses to these mechanisms.¹

There is one aspect of hypertension, however, that seems, in many cases, predictable. "... when the blood pressure is elevated to a marked degree for an adequate period of time, this in itself leads to perpetuation of the syndrome with resulting vascular damage throughout the body."¹⁴ All too often the disease progresses until there is damage to one of three vital organs: the heart, the kidney, the brain.



"Hypertension is certainly a major factor in the genesis of coronary heart disease, and it is even more important when compounded with obesity."⁴

"[Vascular deterioration] can be clearly seen in the kidney with a degree of damage that can be measured by renal function studies."¹⁰

"... most evidence suggests that reduction of blood pressure, when it is too high, not only relieves the heart of excess work but reduces vascular damage."¹

"In short, treatment is indicated."¹

Antihypertensive therapy will not restore the blood vessels to normal. Yet many of the vascular changes and symptoms caused by increased blood pressure may be arrested or alleviated when the blood pressure is reduced to normotensive levels.⁷

Reducing the blood pressure helps curtail further vascular damage and improves the prognosis — when damage is not too far advanced before therapy is started.¹⁴ Essential hypertension is an indication not only for treatment, but for early and adequate treatment of the patient in question.

Reduce the blood pressure with Rautrax-N

Rautrax-N combines the antihypertensive-tranquilizing action of whole root rauwolfia with the antihypertensive-diuretic action of bendroflumethiazide in one convenient medication. The two drugs complement each other

so that smaller doses of both are possible.

Rauwolfia combined with bendroflumethiazide is particularly effective in long-term therapy,¹⁵⁻¹⁷ since beneficial effects do not diminish with continuous daily administration.

For most patients 1 or 2 Rautrax-N tablets daily are sufficient for maintenance therapy. The simplicity, convenience and economy of such a dosage schedule are of particular benefit to older patients.

References: 1. Page, I. H., and Dustan, H. P.: The Usefulness of Drugs in the Treatment of Hypertension, in Ingelfinger, F. J.; Relman, A. S., and Finland, M.: Controversy in Internal Medicine, Philadelphia, W. B. Saunders Co., 1966, p. 95. 2. Hollander, W.: The Evaluation of Antihypertensive Therapy of Essential Hypertension in Ingelfinger, F. J.; Relman, A. S., and Finland, M.: Controversy in Internal Medicine, Philadelphia, W. B. Saunders Co., 1966, p. 97. 3. Nickerson, M.: Antihypertensive Agents and the Drug Therapy of Hypertension, in Goodman, L. S., and Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 3, New York, The Macmillan Co., 1965, p. 727. 4. Berkson, D. M.: Indust. Med. & Surg. 32:371, 1963. 5. Cohen, B. M.: M. Times 91:645, 1963. 6. Lee, R. E., et al.: Am. J. Cardiol. 11:738, 1963. 7. Moyer, J. H.: Am. J. Cardiol. 9:821, 1962. 8. Moser, M.: New York J. Med. 62:1177, 1962. 9. Wood, J. E., and Battley, L. L.: Am. J. Cardiol. 9:675, 1962. 10. Moyer, J. H., and Heider, C.: Am. J. Cardiol. 9:920, 1962. 11. Moser, M., and Macaulay, A. I.: New York State J. Med. 60:2679, 1960. 12. Judson, W. E.: Nebraska M. J. 44:305, 1959. 13. Hodge, J. V.; McQueen, E. G., and Smirk, H.: Brit. M. J. 1:5218, 1961. 14. Moyer, J. H., and Brest, A. N.: Hypertension Recent Advances, Philadelphia, Lea & Febiger, 1961, p. 633. 15. Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. 10:516, 1962. 16. Reid, W. J.: J. Am. Geriatrics Soc. 13:365, 1965. 17. Feldman, L. H.: North Carolina M. J. 23:248, 1962.

Contraindications: Severe renal impairment or previous hypersensitivity. **Warning:** Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting or G.I. bleeding occur.

Precautions and Side Effects: The dose of ganglionic blocking agents, veratrum or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Caution is indicated in patients with depression, suicidal tendencies, peptic ulcer; electrolyte disturbances are possible in cirrhotic or digitalized patients. Marked hypotension during surgery is possible; consider discontinuing two weeks prior to elective surgery and observe patients closely during emergency surgery. Rauwolfia preparations may cause reversible extrapyramidal symptoms and emotional depression, diarrhea, weight gain, edema, drowsiness may occur. Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients, and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, rashes may occur.

Dosage and Supply: Initial dosage, 1 to 4 tablets daily, preferably at mealtime. Maintenance, 1 or 2 tablets daily. Rautrax-N is supplied as capsule-shaped tablets containing 50 mg. Rauwolfia serpentina whole root (Raudixin®), 4 mg. bendroflumethiazide (Naturetin®), 400 mg. potassium chloride.

Also available: Rautrax-N Modified — capsule-shaped tablets containing 50 mg. Rauwolfia serpentina whole root (Raudixin), 2 mg. bendroflumethiazide (Naturetin), 400 mg. potassium chloride. Both potencies available in bottles of 100. For full information, see Product Brief.

RAUTRAX-N

Squibb Rauwolfia Serpentina Whole Root (50 mg.) with Bendroflumethiazide (4 mg.) and Potassium Chloride (400 mg.)

QUIBB

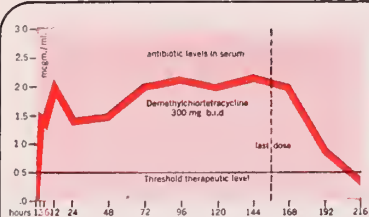


'The Priceless Ingredient' of every product is the honor and integrity of its maker.



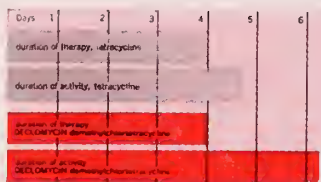
greater potency

lower mg intake per day
600 mg versus 1,000 mg



high activity

From Sweeney, W. M., Dornbush, A. C., and Hardy, S. M.,
Amer. J. Med. Sci. 243:296 (Mar.) 1962



1-2 "extra" days' activity

after the last dose to protect against relapse



one 300 mg Tablet
mid-morning



one 300 mg Tablet
mid-evening

It's made for b.i.d.

in G.U. infections
broad-spectrum performance

DECLOMYCIN[®] DEMETHYLCHLORTETRACYCLINE

Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive.

Contraindication—History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort.

Precautions and Side Effects—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

Capsules: 150 mg; **Tablets:** film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

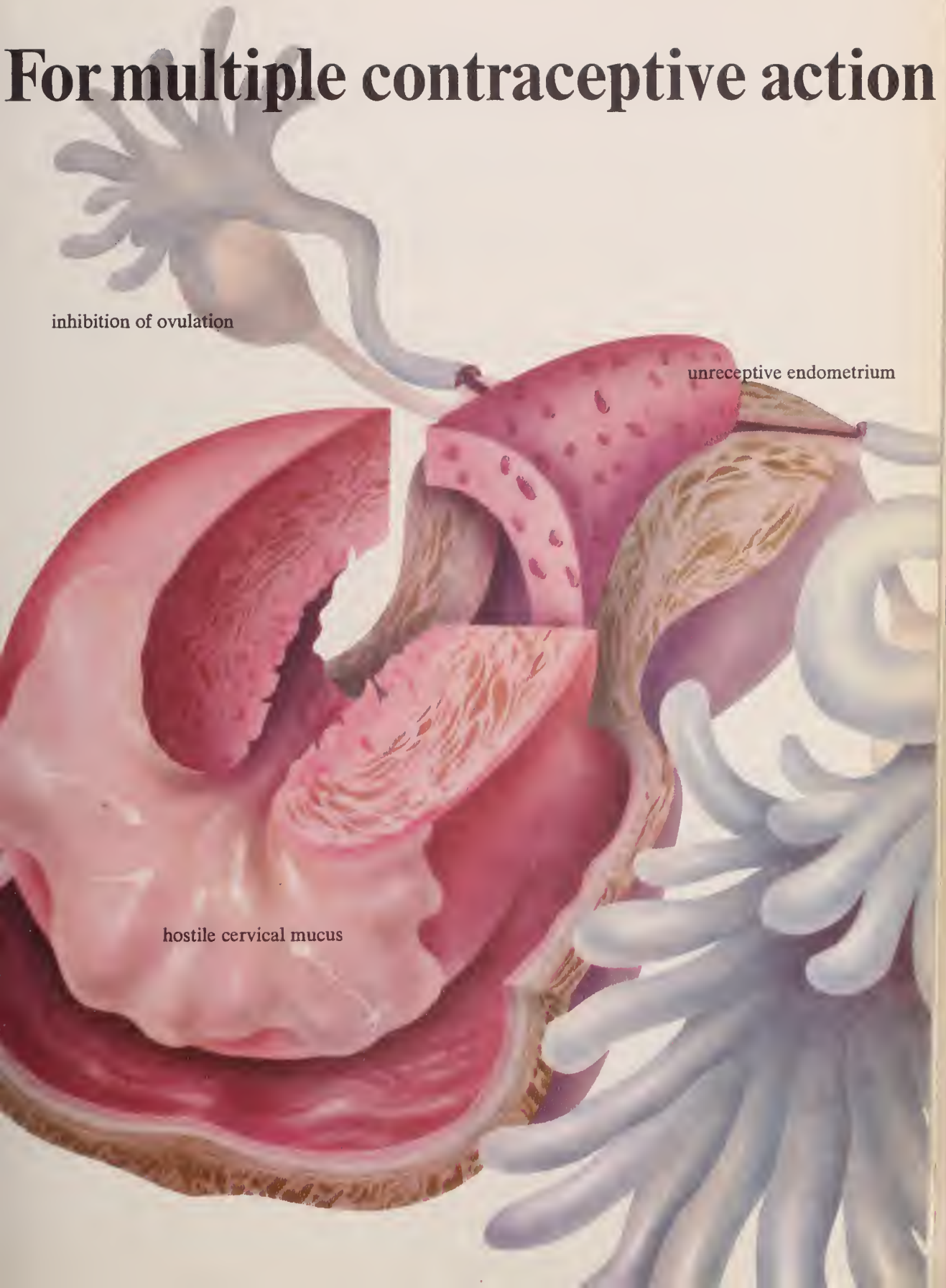


For multiple contraceptive action

inhibition of ovulation

unreceptive endometrium

hostile cervical mucus



Norinyl[®] tablets

(norethindrone 2 mg. \bar{c} mestranol 0.1 mg.)

**multiple action that has produced
a record of unexcelled effectiveness**

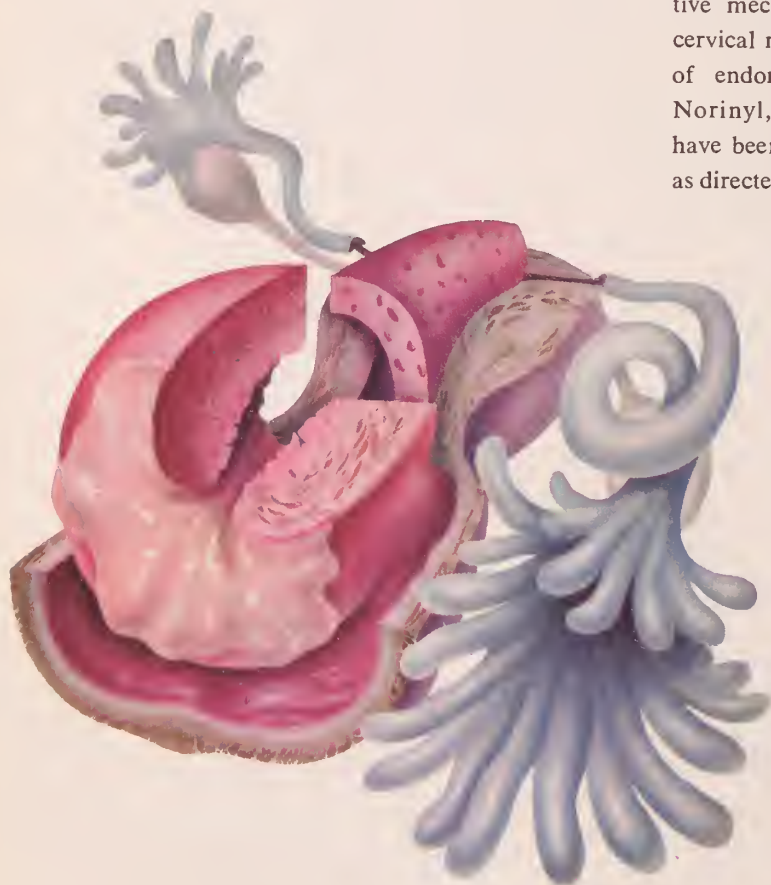
**inhibition of ovulation by means of
2 time-proved hormonal agents**

**production of a cervical mucus hostile to
sperm motility and vitality**

**creation of an endometrium unreceptive
to egg implantation**

no unplanned pregnancies

Norinyl provides multiple action for maximum assurance of success. It does not depend on ovulation inhibition alone for contraceptive effectiveness. The mechanism of action of combined hormonal therapy results in ovulation inhibition reinforced by other protective mechanisms, including a hostile cervical mucus¹⁻¹³ and an acceleration of endometrial changes.^{1-3,7-16} With Norinyl, no unplanned pregnancies have been reported to date when used as directed.



plus important supportive benefits that help her through those critical early months of oral contraception

low incidence of side effects

Low incidence of BTB and spotting, nausea and amenorrhea tends to minimize side effect problems and increases patient cooperation.

no confusion about dosage

An unbreakable "confusionproof" package makes it easy to adhere to prescribed dosage schedule: individually sealed tablets numbered from 1 through 20 *plus* monthly calendar record enables patient to double-check dosage intake by day and corresponding tablet number.



Contraindications: Thrombophlebitis or pulmonary embolism (current or past). Existing evidence does not support a causal relationship between use of Norinyl and development of thromboembolism. While a study which was conducted does not resolve definitively the possible etiologic relationship between progestational agents and intravascular clotting, it tends to con-

firm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.

Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-

ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism. **Side Effects:** Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: 1. Council on Drugs. JAMA 187:664 (Feb. 29) 1964. 2. Bryans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. 3. Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. 4. Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. 5. Hammond, D. O.: Ibid. 6. Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. 7. Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. 8. Kempers, R. D.: GP 29:88 (Jan.) 1964. 9. Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. 10. Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. 11. Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964. 16. Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

norethindrone—an original steroid from
SYNTEX
LABORATORIES INC. PALO ALTO, CALIF.

Norinyl® tablets
(norethindrone 2 mg. • mestranol 0.1 mg.)

for multiple contraceptive action

Anatomy of
Low Back Pain #1



**the sedentary life
is often the seat of
low back pain**

The human spine is not engineered for prolonged sitting at desks, pianos, writers and drafting boards. The stress set up by the heavy, forward-tilted head and trunk, balanced precariously on an insufficient base, result in strain of the dorsal musculature, particularly at the low lumbar level.

The unusual muscle-relaxant and analgesic properties of 'Soma' make it especially useful in the treatment of low back sprains and strains. 'Soma' is prescribed ☐ to relieve pain ☐ to relax muscles ☐ to restore mobility.

Indications: 'Soma' is useful for managing muscle spasm, pain, and stiffness in a variety of inflammatory, traumatic, and degenerative musculoskeletal conditions. It also may act to increase motor activity in certain neurologic disturbances.

Contraindications: Allergic or idiosyncratic reactions to carisoprodol.

Precautions: 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for tolerance, in patients receiving excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

Side Effects: The only side effect reported with frequency is sleepiness, usually on high recommended doses. An occasional patient may not tolerate carisoprodol because of an idiosyncratic reaction, such as a sensation of weakness. Rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and agranulocytosis, occurring when carisoprodol was administered with other drugs, has been reported. An instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have been reported. One case each of anaphylactoid reaction with shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts have been reported to produce coma and/or mild shock and depression.

Dosage: Usual adult dose is one 350 mg. capsule three times daily and at bedtime.

Supplied: Two Strengths: 350 mg. white capsules and 250 mg. orange, two-piece capsules.

Before prescribing, consult package circular.

**for the relief
of low back
sprains and strains**

SOMA
(CARISOPRODOL)



Wallace Laboratories, Cranbury, N.J.



Diagnosis:

cystitis?
pyelonephritis?
pyelitis?
urethritis?
prostatitis?

in any case,
usually gram-negative*

Therapy:

two 500 mg. Caplets® q.i.d.
(initial adult dose)

Effects: Urinary tract infections caused by gram-negative and some gram-positive organisms.

Side Effects: Mainly mild, transient gastrointestinal disturbances; in occasional instances, drowsiness, fatigue, pruritus, rash, urticaria, mild leukopenia, reversible subjective visual disturbances (overbrightness of vision, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), and reversible photosensitivity reactions. In cases of overdosage, coupled with certain predisposing factors, has produced convulsions in a few patients.

Precautions: As with all new drugs, blood and liver function tests are advisable during prolonged treatment. Pending further experience, like most therapeutic agents, this drug should not be given in the first trimester of pregnancy. It must be used cautiously in patients with liver disease or impairment of kidney function. Because photosensitivity reactions have occurred in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the supervision of a physician. Bacterial resistance may develop.

Testing the urine for glucose in patients receiving NegGram, Clinistix® or Tes-Tape® should be used since other reagents give a false positive reaction.

Dosage: Adults: Four Gm. daily by mouth (2 Caplets® of 500 mg. four times a day) for one to two weeks. Thereafter, if prolonged treatment is indicated, dosage may be reduced to two Gm. daily. Children may be given approximately 25 mg. per pound of body weight per day, administered in divided doses. The dosage recommended above for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Until further experience is gained, infants under 1 month of age should not be treated with the drug.

Supplied: Buff-colored, scored Caplets® of 500 mg. for adults, conveniently available in bottles of 56 (sufficient for one full week of therapy) and in bottles of 1000. 250 mg. for children, available in bottles of 56 and 1000.

References: (1) Based on 23 clinical papers, 1512 cases. Bibliography on file. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: Microbial Agents and Chemotherapy - 1964, Ann Arbor, American Society for Microbiology, 1965, p. 722.

NegGram

Brand of

nalidixic acid

a specific anti-gram-negative

eradicates most urinary tract infections...

- Low incidence of untoward effects; no fungal overgrowth, crystalluria, ototoxic or nephrotoxic effects have been observed.

- "Excellent" or "good" response reported in more than 2 out of 3 patients with either chronic or acute gram-negative infections.¹

*As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms: E. coli, Klebsiella, Aerobacter, Proteus, Paracolon or Pseudomonas². However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.

Parke-Davis

Parke-Davis Laboratories, New York, N. Y. 10016

*A Key Site of Action of the
Protoveratrine A in Salutensin*

"The main function of the
carotid sinus is regulation of
the blood pressure...."¹

The veratrum component of
Salutensin acts here (and in the
myocardium), initiating
"...a reflex fall in blood pressure
through a generalized vaso-
dilation and fall in heart rate."²



This is logical Blood Pressure Regulator

USE
NHANCES
BODY'S OWN
ANISMS
REDUCING
D PRESSURE

ld
oderate hypertension:
ensin enhances the body's own
anisms for lowering blood
ure. The veratrum component
utensin acts on the carotid
and myocardial receptors,
ing "...a reflex fall in blood
ure through a generalized
ilation and fall in heart rate."²
ieve this reflex modification
ertension, Salutensin
es protoveratrine A.
dition, to facilitate and
ain blood pressure reduction,
ensin incorporates reserpine
highly effective thiazide.
neral, side effects have been

reported infrequently but
may include those listed in the
therapeutic summary.

**Simple dosage—low-cost
therapy:** Many patients on
Salutensin respond to 1 tablet *b.i.d.*
Long-term economy is assured,
since dosage can frequently
be lowered after initial control is
established.

Available: Prescription-size
bottles of 60 tablets.

References: 1. Editorial: *JAMA*
191:592 (Feb. 15) 1965. 2. Meil-
man, E., in Moyer, J.H.: *Hypertension*, Philadelphia, W.B.
Saunders Company, 1959, p. 395.

BRISTOL THERAPEUTIC SUMMARY
For complete information consult Official
Package Circular.

Indications: Essential hypertension.

Warnings: Small-bowel lesions (obstruc-
tion, hemorrhage, perforation) have oc-
curred during therapy with enteric-coated
formulations containing potassium, with
or without thiazides. Such potassium for-
mulations should be used with Salutensin
only when indicated and should be discon-
tinued immediately if abdominal pain, dis-
tention, nausea, vomiting or gastrointesti-
nal bleeding occurs.

Contraindications: Salutensin is contra-
indicated in severe depression.

Precautions: Azotemia, hypochloremia,
hyponatremia, hypochloremic alkalosis and
hypokalemia (especially with hepatic cir-
rhosis and corticosteroid therapy) may oc-
cur, particularly with pre-existing vomit-
ing and diarrhea. Potassium loss, which
may cause digitalis intoxication, responds
to potassium-rich foods, potassium chlor-
ide or, if necessary, stopping therapy. Se-
rum ammonia elevation may precipitate
coma in precomatose hepatic cirrhotics.
Discontinue therapy two weeks before sur-
gery or if myocardial irritability, progres-
sive azotemia or severe depression occur.
Exercise caution with patients with peptic
ulcers or renal insufficiency (if severe,
Salutensin is contraindicated).

Side Effects: *Hydroflumethiazide:* Purpura
plus or minus thrombocytopenia, hyper-
uricemia, leukopenia, hyperglycemia, gly-
cosuria, malaise, weakness, dizziness, fa-
tigue, paresthesias, muscle cramps, skin
rash, epigastric distress, vomiting, diar-
rhea and constipation. *Reserpine:* Depres-
sion, peptic ulceration, diarrhea, Parkin-
sonism, nasal stuffiness, dryness of the
mouth and, with overdosage, agitation, in-
somnia and nightmares. *Protoveratrine A:*
Nausea, vomiting, cardiac arrhythmia, pros-
tration, excessive hypotension and brady-
cardia. (Treat bradycardia with atropine
and hypotension with vasopressors.)

Usual Dose: 1 tablet *b.i.d.*

BRISTOL

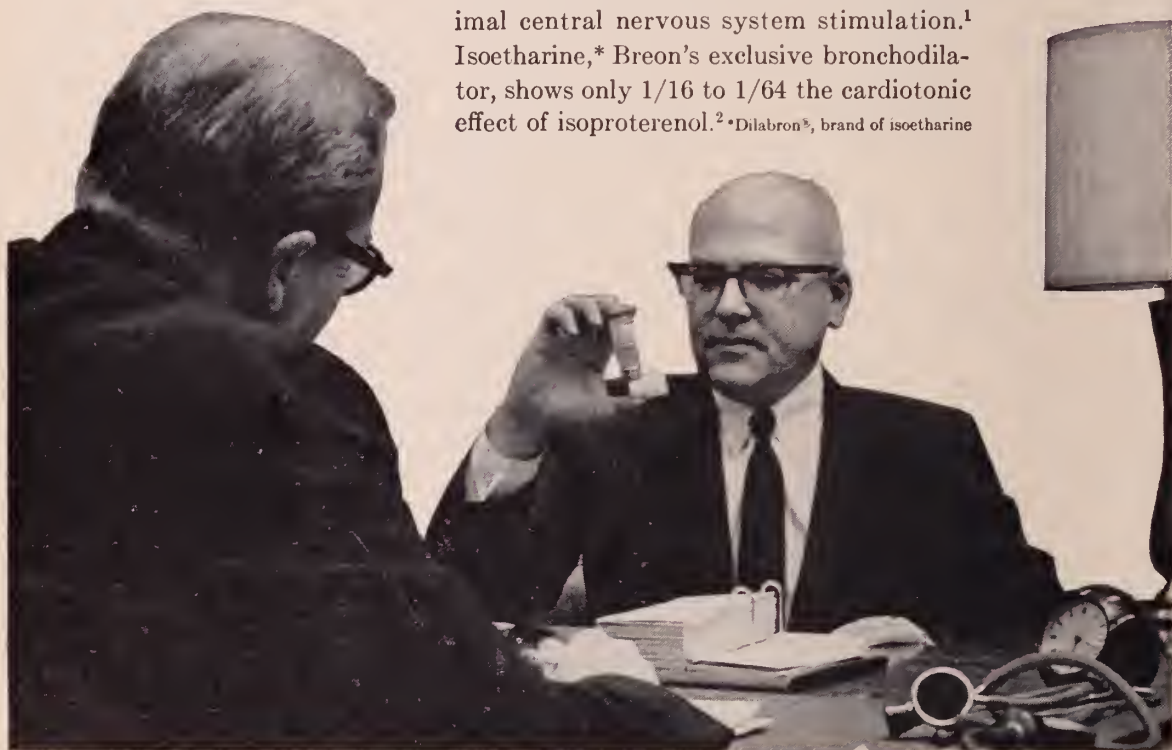
BRISTOL LABORATORIES
Division of Bristol Myers Co.
Syracuse, New York

Salutensin[®]

Each tablet contains:
protoveratrine A, 0.2 mg.;
hydroflumethiazide, 50 mg.;
reserpine, 0.125 mg.

“I like Bronkometer... I breathe better... don't get the jitters.”

Patients feel relaxed with Bronkometer. Its bronchodilator-decongestant action has minimal central nervous system stimulation.¹ Isoetharine,* Breon's exclusive bronchodilator, shows only 1/16 to 1/64 the cardiotoxic effect of isoproterenol.² *Dilabron®, brand of isoetharine



BRONKOMETER® ASTHMA, CHRONIC BRONCHITIS, EMPHYSEMA

isoetharine 0.6%; phenylephrine 0.125%; thenyldiamine 0.05%—Superior because it contains isoetharine

COMPOSITION: Bronkometer delivers at the mouthpiece 200 metered doses of: 350 mcg isoetharine methanesulfonate (0.6%); 70 mcg phenylephrine HCl (0.125%); and 30 mcg thenyldiamine HCl (0.05%) with saccharin, menthol and fluorochlorohydrocarbons as inert propellants. Preserved with ascorbic acid 0.1% and alcohol 30%.

RECOMMENDED DOSAGE: One or two inhalations with at least one minute between inhalations. Occasionally more may be required, however in most cases, inhalations need not be repeated more than every four hours. Dosage should be adjusted to the severity of the condition and to patient's response.

PRECAUTIONS: Bronkometer is unusually free from cardiovascular and other side effects, but the usual precautions associated with sympathomimetic amines should be observed. Bronkometer should not be administered simultaneously with epinephrine or similar compounds because of the possibility of tachycardia, although it may be alternated with these agents. Dosage must be carefully adjusted in patients with hyperthyroidism, hypertension, acute coronary disease, cardiac asthma, limited cardiac reserve and in individuals sensitive to sympathomimetic amines.

SUPPLIED: 10 ml pressurized aerosol vials complete with measured dose valve and oral nebulizer.

References: 1. Spielman, A. D.; *Curr. Therap. Res.* 3:235 (June) 1961. 2. Herschfus, J. A.; Bresnick, E.; Levinson, L.; and Segal, M. S.; *Ann. Allergy* 9:769 (Nov.-Dec.) 1951.



BREON LABORATORIES INC. 90 Park Avenue, New York, N.Y. 10016

The Medical Detective



Death Due to Atrocious Table Manners

In Florida, because of our favorable weather and great variety of attractions, we see more than an average number of visitors who have come down for a rest during their convalescence from a recent illness.

One such visitor was a prominent business man from the North who was in his late fifties. He was recuperating from his second coronary thrombosis. The family physician examined him before leaving and said he was satisfied with the patient's progress and would allow the trip.

Several nights after his arrival the business man went out with his wife and some friends to a nearby steak house. After numerous martinis he got down to the business at hand of consuming a large T-bone steak. He was eating and listening to his friend tell a story when he was seen to stop eating and then to pitch forward face down on the table. Immediate resuscitation was attempted and continued in the ambulance. He was pronounced dead on arrival at the hospital emergency room. The attending physician considered his past history and seeing his bottle of nitroglycerin tablets, assumed that he had died of a heart attack.

The death occurred within the jurisdiction of a County Medical Examiner who was obliged to investigate all deaths which included this sudden unattended death. He was struck by the similar circumstances of this case and that of a death he had investigated a month before. An autopsy was ordered. It was performed by the hospital pathologist and revealed severe muscle damage in the heart. It also revealed severe coronary disease. Both were consistent with the clinical history and did not appear acute. The most interesting finding was a large bolus of steak impacted in the larynx and obstructing the airway. The blood alcohol was high at 0.20 Gm.% (drunk driving—over 0.15 Gm.%).

This entity has been referred to as the "Cafe Coronary" by Dr. Haugen of Fort Lauderdale (JAMA 186:142, 1963). The common factors are acute alcoholism, poor teeth and atrocious table manners.

Given the proper circumstances, including the proximity of a physician recognizing the problem and creating an airway, some of these unfortunate persons may be saved.

WILLIAM G. ECKERT, M.D.
ORLANDO



Government News

Association News



A medicare reference guide with information on what the new program of health insurance for the aged provides and how it works was mailed out in June to the nation's 280,000 physicians.

Developed with the assistance of the American Medical Association and other organizations in the health care field, the reference guide describes the benefits payable for the nation's elderly people under the hospital insurance program. It also describes the payments for doctor bills and other medical services under the voluntary program of medical insurance in which 9 out of 10 of those 65 and over have enrolled.

Included in the guide are examples showing which health services are covered, which are not covered, and what part of the hospital and other medical expenses the medicare program pays.

A Public Health Service-sponsored symposium on disaster preparedness for physicians, dentists, nurses, veterinarians and pharmacists was held in Atlanta, Georgia, April 21-22. In addition to the members of the health professions, representatives of state Civil Defense agencies and the American Red Cross were also invited.

Development of the first experimental vaccine against rubella by two scientists of the Public Health Service's National Institutes of Health was announced recently.

The announcement followed a joint report by the developers of the vaccine, Drs. Harry M. Meyer Jr. and Paul D. Parkman, both of the Division of Biologics Standards, to their scientific colleagues at a recent meeting of the American Pediatric Society.

American Medical Association

The AMA, in a July 21 telegram, announced that the hospital admission certification form mailed hospitals by the American Hospital Association is not necessary. The AMA stated the information required may be part of any admission or progress note signed by the physician stating inpatient services are medically necessary.

The AMA House of Delegates has urged physicians to continue to exercise initiative in the development of effective and efficient utilization review programs.


In adopting a report submitted by the AMA's Council on Medical Service, the House, at its 1965 Clinical Convention, noted that a variety of approaches to utilization review exist. Information on this subject may be obtained by writing the AMA, 535 N. Dearborn St., Chicago, Ill. 60610.

A sample agreement for the operation of a hospital emergency department by a partnership of physicians on the medical staff has been prepared by the American Medical Association.

Developed by AMA's Law Department in cooperation with the Department of Hospitals and Medical Facilities, the sample contract was prepared in response to numerous requests for assistance from hospital medical staffs that have found it difficult to provide staffing through voluntary arrangements.

The sample agreement calls for the partnership to provide the services of a duly licensed physician in the emergency department on a continuous, uninterrupted basis, 24 hours a day seven days a week. Responsibilities of the hospital to provide adequate space, equipment and supplies, maintenance, and nursing and other non-physician services are set forth.

ANNOUNCING a potent combination in
truly delicious orange-flavored forms:
ERYTHROCIN[®]-SULFAS
ERYTHROMYCIN ETHYL SUCCINATE-TRISULFAPYRIMIDINES



in
chewable
tablets

in granules
for oral
suspension

When combination antibiotic
therapy is indicated...



CONSIDER: an exceptionally high cure rate in susceptible infections

The rationale: When combined, Erythrocin and the trisulfapyrimidines (triple sulfas) are indicated in infections that are more susceptible to the combination than to either agent alone. Such conditions are usually found in urinary, lower respiratory tract and chronic ear conditions.

The results: Clinical studies involving 142 young patients showed *an overall cure rate of*

96.5%. Side effects were experienced by only four of the patients.

The acceptance: The majority of the 142 patients studied expressed a definite liking for the products. *There were only two refusals.* An independent taste-test with 50 healthy children further substantiated the excellent acceptability of the orange-flavored forms.

602061

ERYTHROCIN®-SULFAS
ERYTHROMYCIN ETHYL SUCCINATE-TRISULFAPYRIMIDINES

In Chewable Tablets
In Granules for Oral Suspension



ERYTHROCIN[®]-SULFAS

Brief Summary

Indications: Use Erythrocin-Sulfas in infections more susceptible to the combination than to either agent alone. These are usually found in urinary, lower respiratory tract, and chronic ear infections.

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or new born infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions: Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

If a reaction or overgrowth of nonsusceptible organisms occurs, withdraw the drug.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. each of sulfadiazine, sulfamerazine and sulfamethazine. 603303



Meetings

August

- 1- 4 Fifth Inter-American Conference on Toxicology and Occupational Medicine, University of Miami, Miami.
- 12-13 AMA National Conference on Infant Mortality, Fairmont Hotel, San Francisco, California.
- 18-20 Sixteenth Annual Postgraduate Obstetric-Pediatric Seminar, Daytona Plaza Hotel, Daytona Beach.

September

- 16-17 Otolaryngology Seminar, University of Florida, Gainesville.
- 17-13 Fifth Annual Physician's Seminar on Respiratory Diseases, Florida Tuberculosis and Respiratory Diseases Association, Diplomat Hotel, Hollywood.
- 22-24 Cardiovascular Seminar, University of Florida, Gainesville.
- 29-30 Seminar on Diabetes, Florida Diabetes Association, Deauville Hotel, Miami Beach.

October

- 20-22 "Industrial Medicine, The Doctors Role in Occupational Health," Mound Park Hospital Auditorium, St. Petersburg.
- 27-29 Neurology-Neurosurgery Seminar, University of Florida, Gainesville.

November

- 10-12 Pediatric Seminar, University of Florida, Gainesville.
- 17-18 Obstetrics and Gynecology Seminar, University of Florida, Gainesville.
- 17-19 "Pediatric Neurology," Florida Pediatric Society Fall Meeting, Beach Club Hotel, Ft. Lauderdale.

December

- 1- 3 "The Lower Extremity Amputee—Surgery and Prosthetic Management," University of Miami, Americana Hotel, Miami Beach.

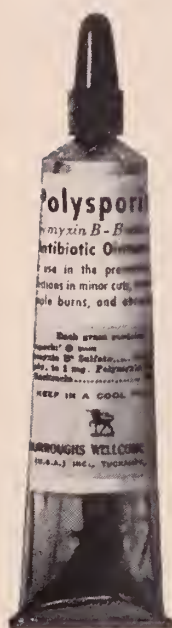
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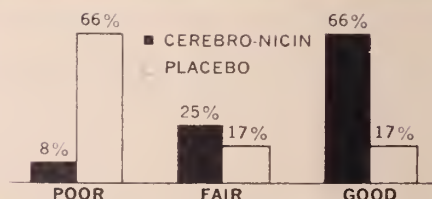


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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jnl. of the Amer. Ger. Soc., June, 1964.

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NEWS

FMA Member Named AFFPRS Pres. Elect

FMA member Richard T. Farrior, M.D., a Tampa otolaryngologist, was named president-elect of the American Academy of Facial Plastic and Reconstructive Surgery, Inc. at the AAFPRS three-day scientific meeting held April 14-16 in San Juan, Puerto Rico.

Dr. Farrior is senior in the attending divisions of plastic surgery and otolaryngology at Tampa General Hospital, director of the Head and Neck Tumor Clinic at Tampa General Hospital, senior attendant in otolaryngology and maxillo-facial surgery at St. Joseph's Hospital and consultant in head and neck surgery, U. S. Veteran's Administration Hospital, Bay Pines.

Jacksonville Pediatrician Establishes Walker Award

Dr. Richard Skinner, a Jacksonville pediatrician and member of the Florida Medical Association, has established the \$50 Dr. James W. Walker Award for excellence in pediatric nursing to be given each year to the Jacksonville University student who has shown the greatest potential for pediatric nursing.

The award was named for Dr. James W. Walker, also a well known Jacksonville pediatrician and chief of staff at

Hope Haven Hospital.

Dr. Walker is active in the Duval County Medical Society and an active supporter of Jacksonville nursing organizations. He is currently chairman of the FMA Committee on Nursing.

Miss Mary Linda Duggan, a member of the 1966 class at Jacksonville University's School of Nursing, has been given the first Dr. James W. Walker Award. In order to receive the award, a student must exhibit an above average scholastic record and possess qualities judged requisite for excellence in the care of children.

Prudential Honors FMA Member

Dr. W. Hugh Mathews recently was appointed Associate Medical Director with the South-Central home office of the Prudential Insurance Co. of America.

Dr. Matthews is a member of the Duval County Medical Society and the FMA. An attending staff member at Duval Medical Center, Dr. Mathews has been in the private practice of internal medicine in Jacksonville for a number of years. He attended Emory University in Atlanta, and received his M.D. degree from Emory's School of Medicine in 1946.

Two Florida Boys Win Top AMA Honors

Two Florida boys have won top honors at the 17th International Science Fair held May 11-14 in Dallas, Texas.

Winner of one of the two top American Medical Association awards was Robert Carter Dillingham, a junior at Leon High School in Tallahassee. He was selected for the honor on his work entitled "Analysis of Hematoxins and Neurotoxins," which compares the effects of water moccasin and black widow spider venoms on animals and animal tissues.

The award consisted of a citation and an all-expense paid trip as an official guest of the AMA to its 115th Annual Convention.

Daniel Walker Becton of Indiatlantic was given one of the ten "Award of Merit" certificates for his study on "A Structural Basis for Biochemical Alteration of Memory."

The studies were selected by a special AMA committee from the AMA Council on Postgraduate Programs from among 419 finalists from 48 states, Canada, Costa Rica, Japan, the Philippines, Puerto Rico, Sweden and West Germany. The awards were presented by Dr. James Z. Appel, AMA president.

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Creeping eruption is caused by the larvae of the dog and cat hookworm, *Ancylostoma Braziliense*. The larvae of this parasite burrow between the superficial layers of the skin, causing much discomfort and characteristic angry eruptions.

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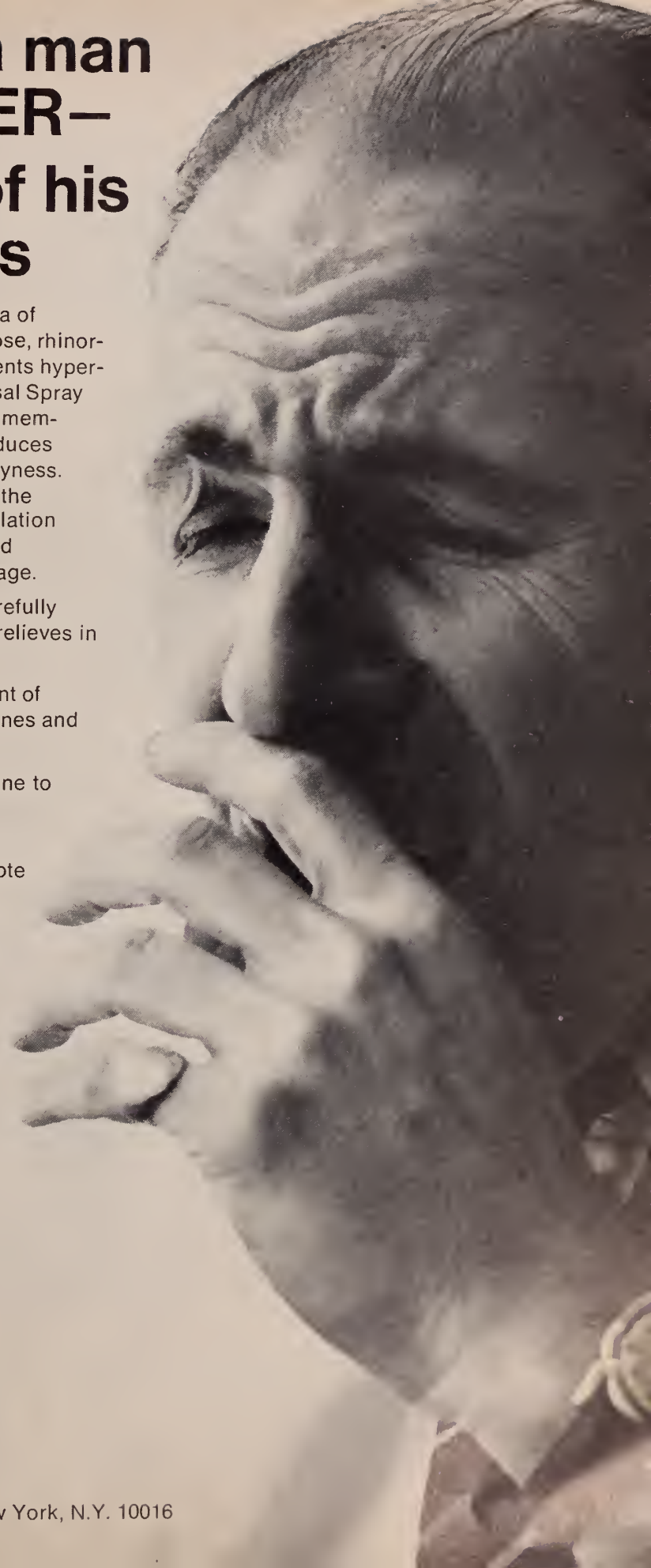
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(Public Law 89-97)

Part A - Hospitalization

YOUR BENEFITS

YOUR COSTS

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| <p>1. A maximum of 90 days of hospital care in each spell of illness. (A spell of illness begins with the first day you are furnished inpatient hospital or nursing home care, and ends when you have been out of a hospital or nursing home for 60 consecutive days.) Up to 60 days paid for by the government, after you pay the first \$40 of your hospital bill; 30 additional days, if required, for which you pay \$10 per day.</p> | <p>1. The first \$40 of the hospital bill.
\$10 per day for each day in the hospital after 60 days.</p> |
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- | | |
|---|---|
| <p>2. Outpatient diagnostic service. Includes x-rays and laboratory tests. You pay the first \$20 of the cost of each study and 20% of all costs over \$20. All diagnostic services furnished by the same hospital during a 20-day period are counted as one study.</p> | <p>2. The first \$20 of the cost of each diagnostic study, plus 20% of all costs of each study over \$20. The physician's fee is not covered unless he is an intern or resident in an approved training program. Those enrolled in Part B can credit the \$20 against the deductible under that plan.</p> |
|---|---|
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| <p>3. Post-hospital extended care (nursing homes). Up to 100 days after you have spent at least three days in a hospital and are admitted within 14 days after discharge from the hospital. The government pays for the first 20 days. You pay \$5 per day for the remaining 80 days. (This program does not begin until Jan. 1, 1967.)</p> | <p>3. \$5 per day for every day after the first 20 days.</p> |
|---|--|
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| <p>4. Home health care, Up to 100 home-health visits by a nurse, therapist, or home health aide when prescribed by a physician, after you have stayed at least three days in a hospital and the plan is started within 14 days after your discharge. (Physician's visits are covered only under the supplemental Part B of the Act.)</p> | <p>4. No charge.</p> |
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Part B – Medical Services

YOUR BENEFITS

1. Physicians' services, including surgery, consultation, and home, office and institutional calls. Dentists also are included when performing surgery related to the jaw or reducing a fracture of the jaw or any facial bone.
2. Medical and other health services, including:
Diagnostic x-ray and laboratory tests; services and supplies furnished in connection with the physician's services, if commonly furnished in his office; hospital services connected with the physician's services to outpatients; drugs which cannot be self-administered; surgical dressings, splints, casts and other devices for correction of fractures and dislocations; rental of durable equipment, such as iron lungs, oxygen tents, hospital beds and wheel chairs; artificial devices (other than dental) that replace all or part of an internal body organ; braces and artificial limbs; ambulance service when deemed necessary by a physician.
3. Home health visits up to a maximum of 100 per year, without a requirement of prior hospitalization.

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The law provides that the physician may receive his fee in either one of two ways:

1. The physician may elect to deal directly with you as he has in the past. In this case, you will send or take his receipted, itemized bill—or the form provided by the Social Security Administration—to the insurance carrier in your area who has been selected to represent the government in the handling of funds for the program. From the carrier you will receive the amount allowed for the services stated on the receipted bill, less the \$50 deductible (if not previously incurred) and the 20% share of the bill which the law requires you to pay.

2. The physician may elect to accept his fee from the carrier. In this case, he will expect you to pay the \$50 deductible and your 20% share of the charges. He will receive the balance from the carrier upon presentation of an assignment which you have given him.

For further information on Public Law 89-97, consult your local Social Security Administration Office

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1. Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

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Side effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is a concomitant administration of a coronary vasodilator.

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(trichlormethiazide)

oral diuretic

Dosage: One 2 or 4 mg. tablet once or twice daily.

Precautions: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

Side Effects: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have occasionally been noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by the administration of thiazides.

Contraindications: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

How Supplied: Bottles of 100 and 1000 tablets.

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2 mg. or 4 mg. and
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Usual adult dose: One tablet twice daily. **Precautions and side effects:** Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery.

Contraindications: Complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.

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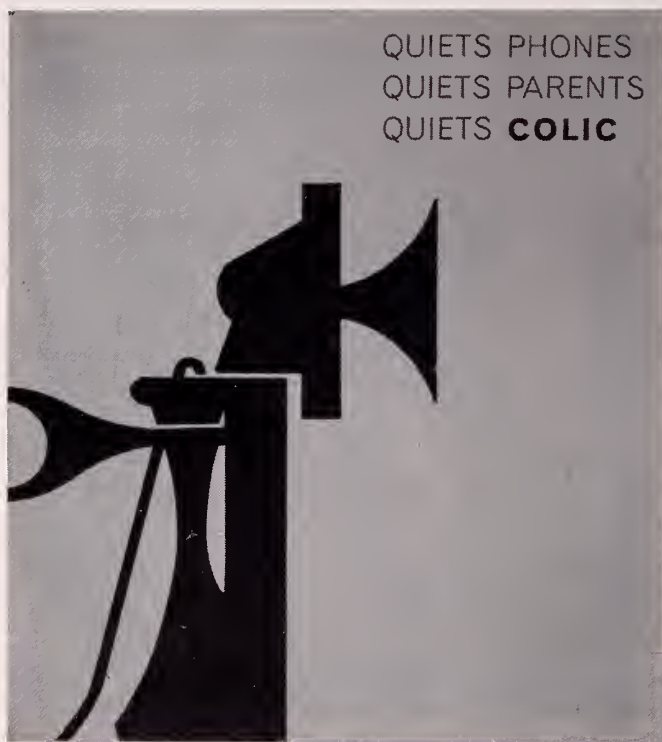
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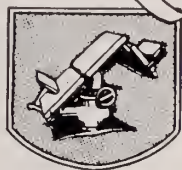
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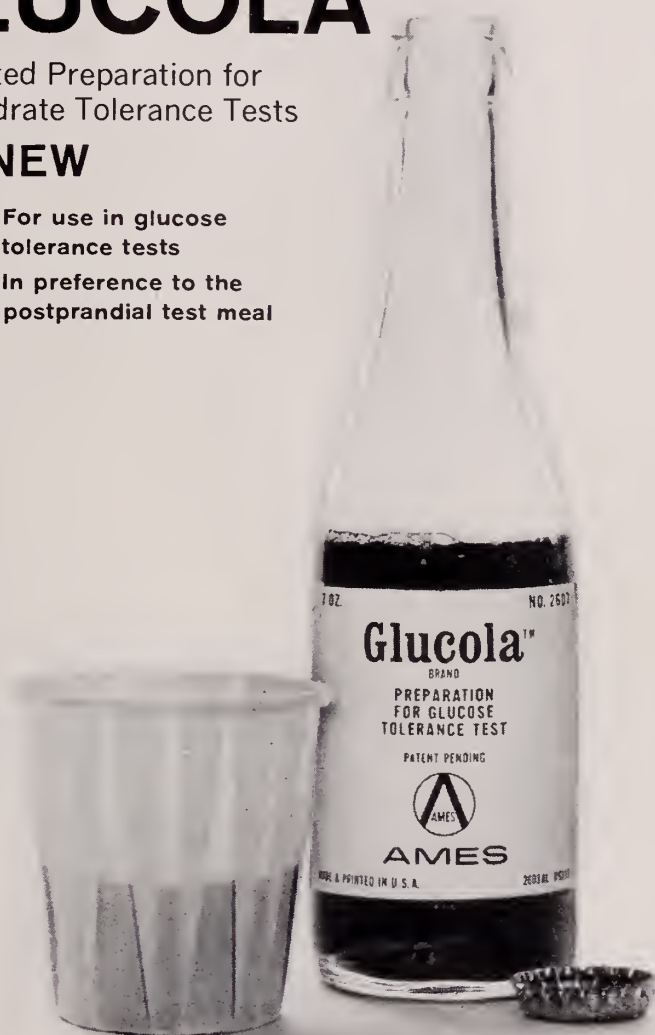
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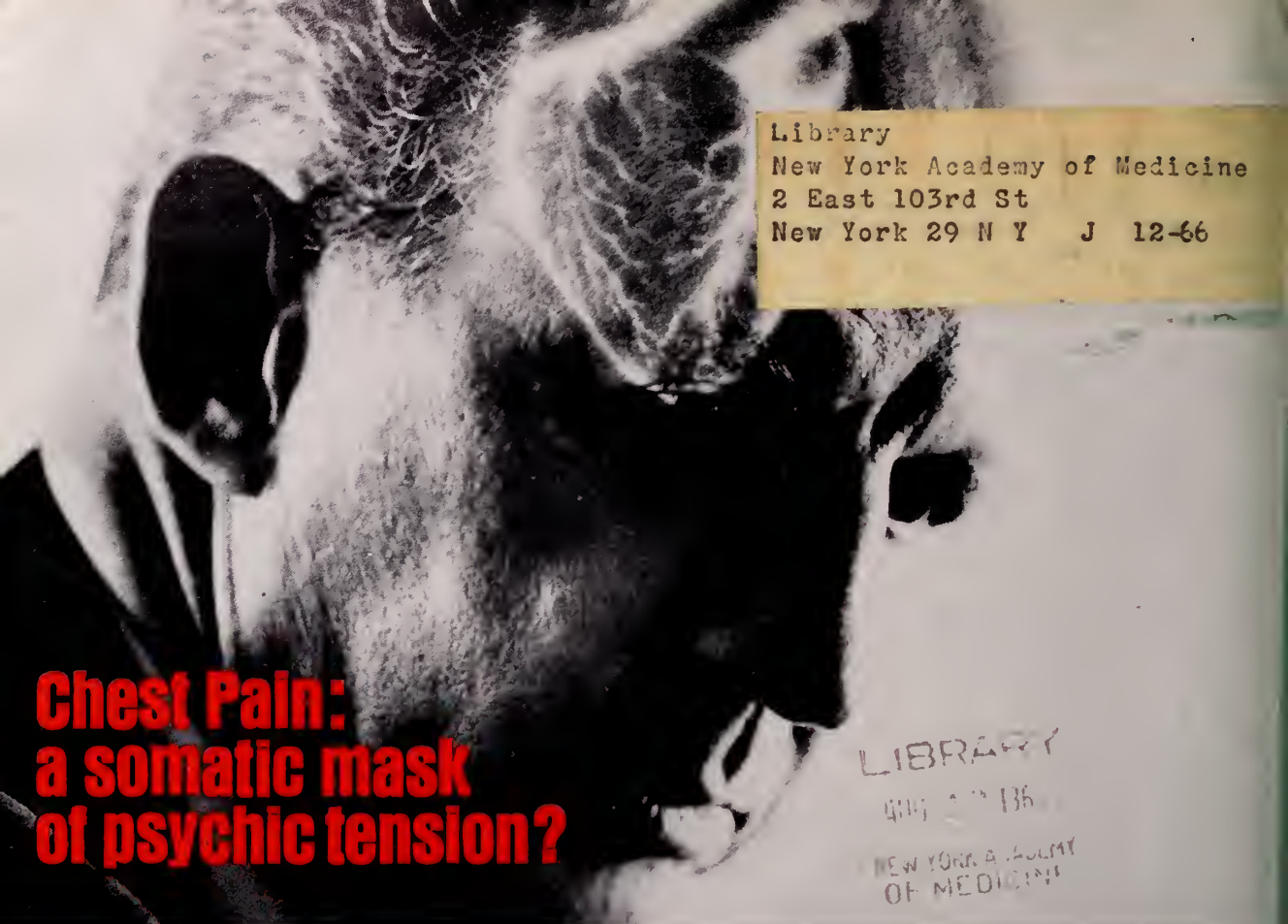
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Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances and hallucinations) at changes in EEG patterns. Abrupt cessation after prolonged over dosage may produce withdrawal symptoms similar to those seen with barbiturates, meprobamate and chlorthalidoxepoxide HCl.

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SEPTEMBER, 1966

Volume 53

Number 9

The **JOURNAL**
of the Florida Medical Association

Crash and Survive

Creeping Eruption

Treatment of Varicoceles

Medicare and the Doctors

Thinking on Antidepressants

The Urge for Self Destruction

OFFICIAL PUBLICATION

M OF THE **D**
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a sea of trouble for pollen-sensitive patients



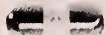
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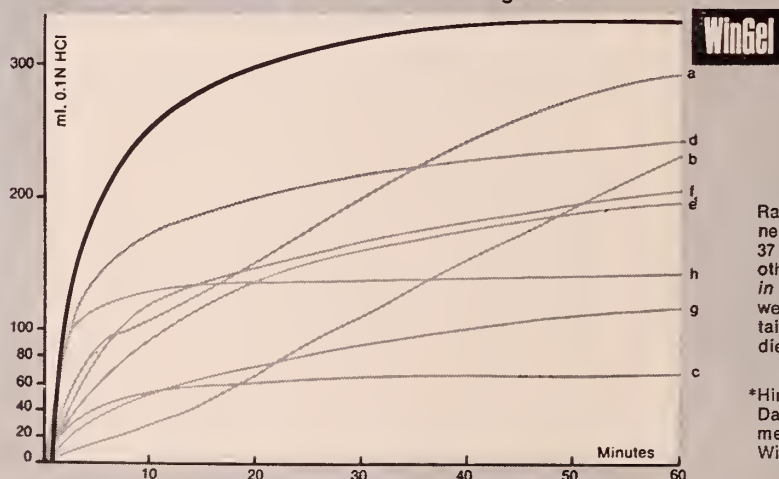
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The JOURNAL

of the Florida Medical Association

Volume 53, Number 9, September 1966

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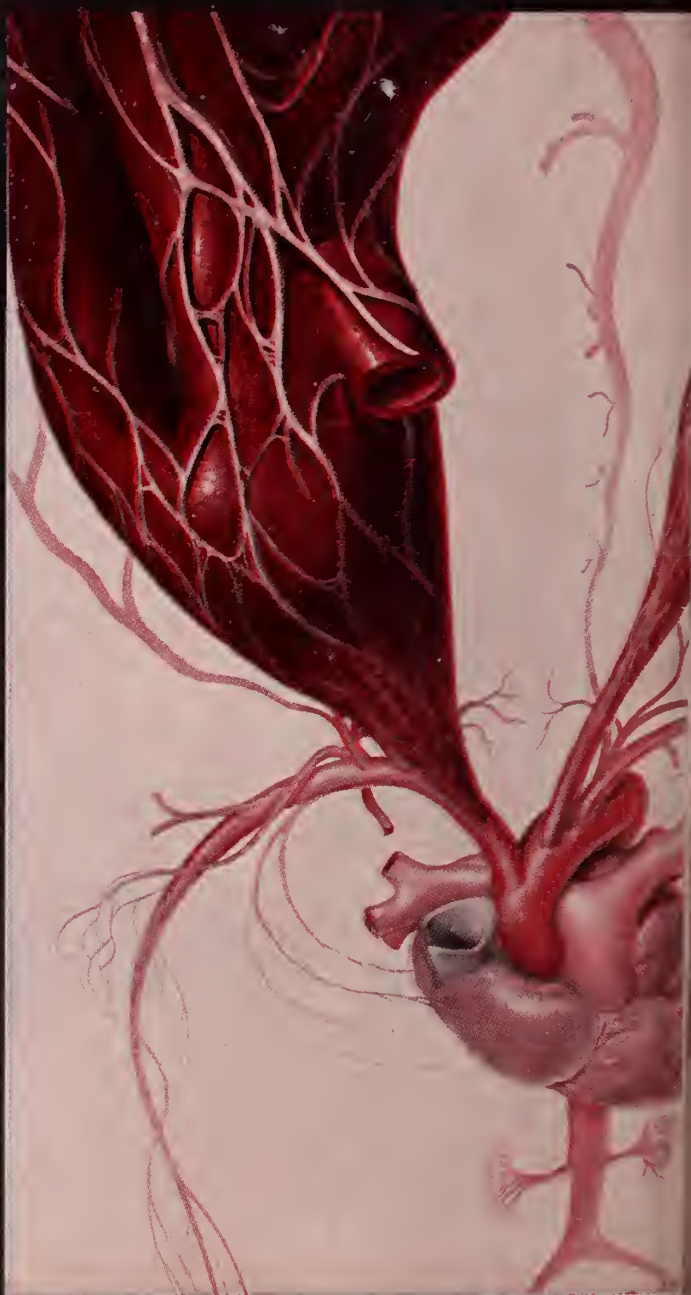
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utilizes protoveratrine A.
In addition, to facilitate and
maintain blood pressure reduction,
Salutensin incorporates reserpine
and a highly effective thiazide.
In general, side effects have been

reported infrequently but
may include those listed in the
therapeutic summary.

**Simple dosage—low-cost
therapy:** Many patients on
Salutensin respond to 1 tablet *b.i.d.*
Long-term economy is assured,
since dosage can frequently
be lowered after initial control is
established.

Available: Prescription-size
bottles of 60 tablets.

References: 1. Editorial: JAMA
191:592 (Feb. 15) 1965. 2. Meil-
man, E., in Moyer, J.H.: Hyper-
tension, Philadelphia, W. B.
Saunders Company, 1959, p. 395.

BRISTOL THERAPEUTIC SUMMARY
For complete information consult Official
Package Circular.

Indications: Essential hypertension.

Warnings: Small-bowel lesions (obstruc-
tion, hemorrhage, perforation) have oc-
curred during therapy with enteric-coated
formulations containing potassium, with
or without thiazides. Such potassium for-
mulations should be used with Salutensin
only when indicated and should be discon-
tinued immediately if abdominal pain, dis-
tention, nausea, vomiting or gastrointestinal
bleeding occurs.

Contraindications: Salutensin is contra-
indicated in severe depression.

Precautions: Azotemia, hypochloremia,
hyponatremia, hypochloremic alkalosis and
hypokalemia (especially with hepatic cir-
rhosis and corticosteroid therapy) may oc-
cur, particularly with pre-existing vomit-
ing and diarrhea. Potassium loss, which
may cause digitalis intoxication, responds
to potassium-rich foods, potassium chlor-
ide or, if necessary, stopping therapy. Se-
rum ammonia elevation may precipitate
coma in precomatose hepatic cirrhotics.
Discontinue therapy two weeks before sur-
gery or if myocardial irritability, progres-
sive azotemia or severe depression occur.
Exercise caution with patients with peptic
ulcers or renal insufficiency (if severe,
Salutensin is contraindicated).

Side Effects: *Hydroflumethiazide:* Purpura
plus or minus thrombocytopenia, hyper-
uricemia, leukopenia, hyperglycemia, gly-
cosuria, malaise, weakness, dizziness, fa-
tigue, paresthesias, muscle cramps, skin
rash, epigastric distress, vomiting, diar-
rhea and constipation. *Reserpine:* Depres-
sion, peptic ulceration, diarrhea, Parkin-
sonism, nasal stuffiness, dryness of the
mouth and, with overdosage, agitation, in-
somnia and nightmares. *Protoveratrine A:*
Nausea, vomiting, cardiac arrhythmia, pros-
tration, excessive hypotension and brady-
cardia. (Treat bradycardia with atropine
and hypotension with vasopressors.)

Usual Dose: 1 tablet *b.i.d.*

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Co
Syracuse, New York

Salutensin[®]

Each tablet contains:
protoveratrine A, 0.2 mg.;
hydroflumethiazide, 50 mg.;
reserpine, 0.125 mg.

Norinyl[®] tablets

(norethindrone 2 mg. \bar{c} mestranol 0.1 mg.)

for multiple contraceptive action that has produced a record of unexcelled effectiveness

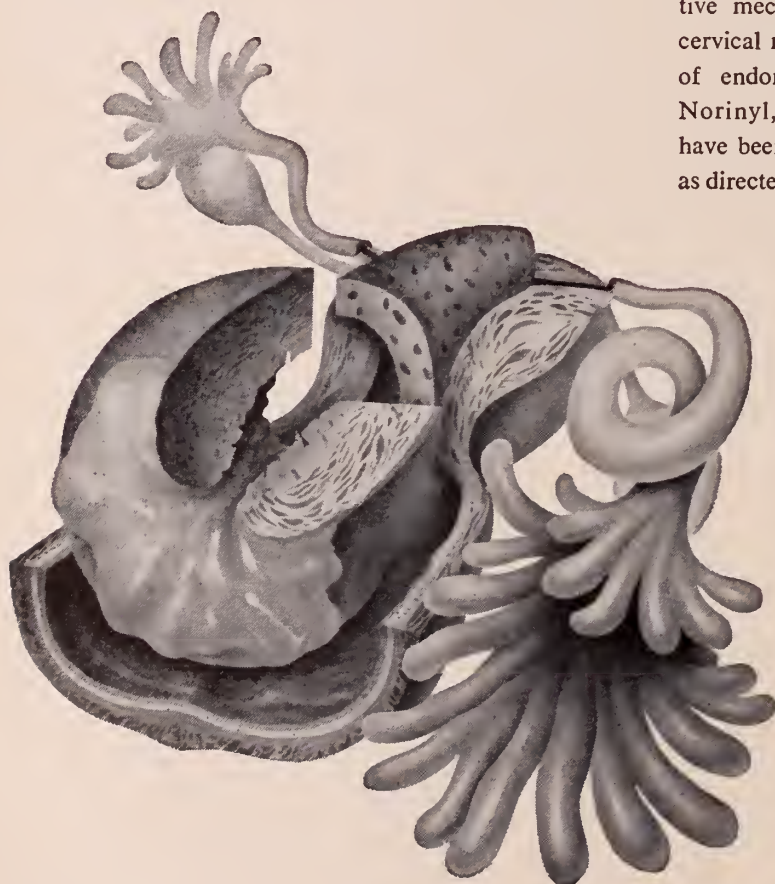
**inhibition of ovulation by means of
2 time-proved hormonal agents**

**production of a cervical mucus hostile to
sperm motility and vitality**

**creation of an endometrium unreceptive
to egg implantation**

no unplanned pregnancies

Norinyl provides multiple action for maximum assurance of success. It does not depend on ovulation inhibition alone for contraceptive effectiveness. The mechanism of action of combined hormonal therapy results in ovulation inhibition reinforced by other protective mechanisms, including a hostile cervical mucus¹⁻¹³ and an acceleration of endometrial changes.^{1-3,7-16} With Norinyl, no unplanned pregnancies have been reported to date when used as directed.



plus important supportive benefits that help her through those critical early months of oral contraception

low incidence of side effects

Low incidence of BTB and spotting, nausea and amenorrhea tends to minimize side effect problems and increases patient cooperation.

no confusion about dosage

An unbreakable "confusionproof" package makes it easy to adhere to prescribed dosage schedule: individually sealed tablets numbered from 1 through 20 *plus* monthly calendar record enables patient to double-check dosage intake by day and corresponding tablet number.



Contraindications: Thrombophlebitis or pulmonary embolism (current or past). Existing evidence does not support a causal relationship between use of Norinyl and development of thromboembolism. While a study which was conducted does not resolve definitively the possible etiologic relationship between progestational agents and intravascular clotting, it tends to con-

firm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.

Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-

ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism. Side Effects: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: 1. Council on Drugs. JAMA 187:664 (Feb. 29) 1964. 2. Brivans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. 3. Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. 4. Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. 5. Hammond, D. O.: Ibid. 6. Rice-Wray, E.: Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. 7. Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. 8. Kempers, R. D.: GP 29:88 (Jan.) 1964. 9. Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. 10. Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. 11. Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964. 16. Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

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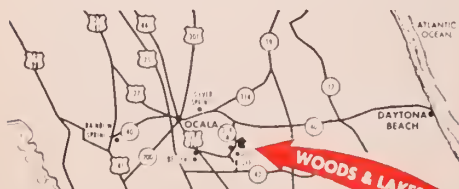
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Season

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this issue: emergency anesthesia and the common cold

When emergency anesthesia is complicated by the common cold

Barry Belonsky, M.D., F.A.C.A.

Staff Anesthesiologist, Hospital of The Albert Einstein College of Medicine, New York City



Medical facilities are often presented with unfamiliar patients who have unknown health histories. This is particularly true in emergency situations that arise due to accidents or acute illnesses. These cases may need prompt care re-

quiring anesthesia, and if they involve colds, nasal allergies or other upper respiratory infections, can account for many complications which make up a major hazard during emergency anesthesia.

Administration of general anesthesia to a patient with a cold or upper respiratory infection is a hazardous undertaking. It should be avoided if at all possible. Indeed, the presence of U.R.I. is good reason for postponement of elective surgery.¹ In emergency surgery, regional or local block should be considered, but if general anesthesia is mandatory, it should be approached with utmost caution.

Since the attitude of "emergency surgery — hurry" has been replaced by "emergency surgery — watch out";² a knowledge of the complications is a great help in preventing them. Here is a brief outline of the problems involved and their treatment. Prevention of the complications is discussed later.

Complications during the induction of anesthesia

Most of the complications are a direct result of secretions and some a result of accompanying secondary infection. For example, *airway obstruction* due to excessive secretions occurs very commonly and is the direct effect of the cold. Respiratory exchange may be obstructed at any time during anesthesia because of excessive secretions, but is most likely to occur during induction. Suction apparatus must be available to overcome this.³

Excess secretions which stimulate and irritate the epiglottis and vocal chords can cause *laryngeal stridor and obstruction*. This can lead to complete laryngeal closure with resultant anoxia and death.

Bronchospasm and laryngospasm can result from secretions penetrating the bronchi and bronchioles. In laryngospasm, there are both inspiratory and expiratory stridor and difficulty in inflating the chest; in bronchospasm there is an expiratory wheeze, but not as much difficulty in inflation, although some resistance may be felt. Stridor is due to partial or complete closure of the vocal cords in spasm and the "crowing" sound is almost pathognomonic.

Secretions obstruct the nasal airways. This produces *difficulty in ventilation* through the mouth until the patient is deep enough to place an oral airway. An intravenous agent can be given to facilitate the induction of anesthesia.

Difficulties can arise if intubation is performed to ventilate the patient. For example, teeth can be broken by too vigorous attempts at intubation, or the intubation itself may be technically difficult due to secretions obstructing the view of the glottis. The postoperative sequelae of intubation ranges from mild laryngitis to pneumonia with atelectasis, and are seen far more commonly in patients suffering from colds than in normal patients.



Successive stages of laryngospasm which produce the characteristic stridor or "crowing" sound.



*Progression of
bronchioles into bronchospasm.*

Complications during the maintenance of anesthesia *Bronchospasm* can occur in an unintubated patient due to secretions entering the bronchial tree from above, and acting as an irritant to the bronchi and bronchioles. Secretions accumulate quickly and the patient has to be suctioned continually. The whole cycle of coughing, bucking, laryngospasm and bronchospasm may ensue. The difficult decision here is whether it is better to suction the patient continually or to use an endotracheal tube which protects the cords and bronchi but introduces the risk of attendant complications.

Postoperative complications Postoperatively, complications can be more serious than even the intranasal anesthesia complications, and occur much more frequently in a patient who has been intubated.⁴

Sore throat and pharyngitis can result both from the preoperative upper respiratory infection and from the drying of the mucous membranes which occurs during anesthesia.

Tracheitis and bronchitis often result from secretions trickling down the tracheobronchial tree.

Laryngitis is frequently seen in patients with upper respiratory infections who have been intubated. There is a significant increase in the incidence of laryngitis compared to that in patients without upper respiratory infections.

Subglottic edema is a condition which occurs mainly in children who have been intubated. This pathology results from an exudate developing in the areolar tissue just below the cords. Because of the small size of the child's trachea, even a 1 mm increase in

size of the mucous membrane can severely impair the air passage. Children exhibit this by severe expiratory stridor and may even become cyanotic. This may so severely embarrass the child's breathing that it must be treated vigorously. Most authorities agree on the treatment^{5,6,7,8} consisting of a high oxygen concentration in the inspired air (60%), plus high humidity (close to 100%). Adequate parenteral fluid intake and slight cooling of the body temperature (by a cooled oxygen tent) also help in mild cases. In severe cases, there may be hypoxia which increases the restlessness and the oxygen demand rises. Sedation is often necessary, although concomitant depression of the respiratory center is undesirable. An antihistaminic accomplishes this purpose well, and adds sedation. Since there is always a possibility that an allergic response plays a role in edema, some relief of the respiratory distress may occur. Steroids should be used to control inflammatory and allergic phenomena and swelling. If all this fails, and the patient is still restless and hypoxic, a tracheostomy should be performed immediately.

(concluded on following page)



Your patient can breathe easily, flying from New York to Rome, on just one Triaminic timed-release tablet.

One tablet goes a long way. For 24 hour relief of nasal congestion and postnasal drip due to sinusitis, colds and respiratory allergies—simply prescribe one Triaminic timed-release tablet, swallowed whole, in morning, mid-afternoon and at bedtime.

Side Effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness, or gastrointestinal upsets. **Precautions:** The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

Each **Triaminic**[®] timed-release tablet contains...

Phenylpropanolamine hydrochloride	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

(Advertisement)



Cross section of trachea showing subglottic edema and lumen reduction due to mucous membrane congestion.

Pneumonia may also follow anesthesia administered to a patient with a cold. This can be caused by accumulated secretions becoming secondarily infected and causing consolidation of the lung. *Atelectasis* of the lung can result if one of the bronchioles becomes plugged by secretions, preventing aeration of the distal part of that lung. This is seen more frequently following upper respiratory infection because dry anesthetic gases aggravate the infection, causing secretions to change from watery to thick and viscid, and consequently difficult to suction.

Prevention of complications The first rule to prevent complications, of course, is to use a regional or local anesthesia whenever possible. But when emergency surgery is a must, in spite of the presence of a cold, allergy, or upper respiratory infection, here are some ways to prevent complications.

Give nose drops preoperatively. This can help shrink the congested nasal mucous membranes and reduce secretions for better air passage. (Results of this method are sometimes unsatisfactory because of the short duration of effect or rebound congestion.) For longer effect, oral antihistamines with nasal decongestants are often given to provide and maintain a drying effect on secretions.

To clear the tracheobronchial tree, instruct the patient to cough preoperatively. Cold steam or water nebulizers effectively humidify the nasal, pharyngeal and bronchial passages and often make the patient more comfortable. Tenacious secretions be-

come more watery under humidification, clear more thoroughly preoperatively and are more easily suctioned from the airway during anesthesia.

Give intravenous fluids to those patients who appear dehydrated due to a cold. In a well hydrated patient the respiratory tract secretions are less viscid and more watery. This is particularly true in asthmatics.

Summary: Administration of emergency anesthesia to a patient with a cold or upper respiratory infection can lead to a chain of events that may result in increased postoperative morbidity and even death. This is because of the excess secretions formed in these conditions. Preoperative measures to prevent or reduce these secretions should be undertaken and will result in smoother and safer anesthesia.

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2. Smith, R. M.: Anesthesia for Infants and Children, 1963, p. 353.
3. Gillespie, Noel A.: Endotracheal Anesthesia, 1963, p. 155 et seq.
4. Smith, R. M.: Anesthesia for Infants and Children, 1963, p. 353.
5. Written, F. W.: Postoperative Laryngeal Stridor, *British Journal of Anesthesia*, 1966, Vol. 38, p. 73.
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Dosage: Adults—2 teaspoonfuls; Children 6 to 12 years—1 tsp.; Children 1 to 6 years—½ tsp. Administer every four hours. **Side effects:** Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness, gastrointestinal upsets. **Precautions:** The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

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**the sedentary life
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low back pain**

The human spine is not engineered for prolonged sitting at desks, pianos, typewriters and drafting boards. The stresses set up by the heavy, forward-tilted head and trunk, balanced precariously on an insufficient base, result in strain of the dorsal musculature, particularly at the low lumbar level.

The unusual muscle-relaxant and analgesic properties of 'Soma' make it especially useful in the treatment of low back sprains and strains. 'Soma' is widely prescribed ☐ to relieve pain ☐ to relax muscles ☐ to restore mobility.

Indications: 'Soma' is useful for management of muscle spasm, pain, and stiffness in a variety of inflammatory, traumatic, and degenerative musculoskeletal conditions. It also may act to normalize motor activity in certain neurologic disturbances.

Contraindications: Allergic or idiosyncratic reactions to carisoprodol.

Precautions: 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

Side Effects: The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

Dosage: Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

Supplied: Two Strengths: 350 mg. white tablets and 250 mg. orange, two-piece capsules.

Before prescribing, consult package circular.

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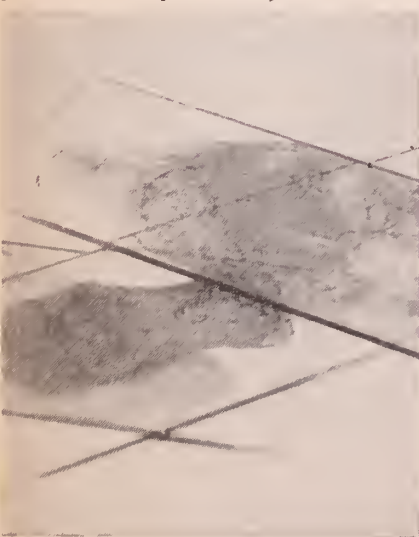
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2. nonpregnant women with a history of recent or recurrent monilial vaginitis
3. elderly or debilitated patients



4. patients with a past history of moniliasis
5. patients on long-term tetracycline or corticosteroid therapy



BRISTOL THERAPEUTIC SUMMARY: For complete information consult Official Package Circular. **Indications:** Infections of respiratory, gastrointestinal and genital tracts and skin and soft tissues due to tetracycline sensitive organisms, in patients with increased susceptibility to monilial infections. **Contraindications:** The drug is contraindicated in patients hypersensitive to its components. **Warnings:** Photodynamic reactions have been reported with tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discoloration occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, low dosage should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). **Precautions:** Bacterial superinfection may occur. Infants may have increased intracranial pressure with bulging fontanelles. Gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. **Reactions:** Glossitis, stomatitis, nausea, diarrhea, proctitis, vaginitis, dermatitis, and allergic reactions may occur. **Usual Adult Dosage:** 1 capsule q.i.d. for 10 days in beta-hemolytic streptococcal infections. Administer one hour before or 2 hours after meals. **Supply:** Capsules, bottles of 16. Each capsule contains tetracycline phosphate complex equivalent to 250 mg tetracycline HCl activity and 250,000 units of nystatin.

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Indications: Meprobamate is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, meprobamate fosters normal sleep through both its anti-anxiety and muscle-relaxant properties.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses.

Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

Supplied: 'Miltown' (meprobamate) is available in two strengths: 400 mg. scored tablets and 200 mg. coated tablets. 'Mepro tabs' (meprobamate) is available as 400 mg. white, coated, unmarked tablets. *Before prescribing, consult package circular.*

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DIUTENSEN-R is thiazide and reserpine *plus* cryptenamine — a rational, comprehensive therapy to help establish and maintain early, more decisive control of blood pressure.

The cryptenamine in DIUTENSEN-R helps improve normal vasodilating reflexes while the thiazide and reserpine components maintain vasorelaxant, sedative, and saluretic benefits. Cryptenamine lowers pressoreceptor reflex thresholds (which may be abnormally high in hypertension) — “resets” pressoreceptors to function at more nearly normotensive levels.

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“... quite apart from the problem of vascular damage, there arises a possibility of virtual ‘cure’ or remission of hypertension when treatment is early, i.e., before too many other secondary pressor systems have entered into the disequilibrium of pressor control, and when it is adequately suppressive.”

Corcoran, A. C.: The choice of drugs in the treatment of hypertension. In: *Drugs of Choice* 1966-67, W. Modell, Ed., St. Louis, C. V. Mosby Company, 1966, p. 417.

Indications: DIUTENSEN-R may be employed in all grades of essential hypertension.

Dosages: Usual dose is 1 tablet twice daily, at morning and evening meals.

However, adjustment of dosage to suit individual circumstances may be required. Please refer to package insert for full particulars. **Side effects and**

precautions: The side effects observed with patients on DIUTENSEN-R have been of a mild and nonlimiting nature. These include occasional urinary frequency, nocturia, nasal congestion, muscle cramps, skin rash, joint pains due to gout symptoms and nausea and dizziness which have been reported for the individual components. Most of these symptoms disappear while the drug is continued at the same or lower dosage level. The concomitant use of digitalis and DIUTENSEN-R may increase the possibility of digitalis-like intoxication. If there is evidence of myocardial irritability (extrasystoles, bigeminy or AV block), dosage of DIUTENSEN-R should be reduced or discontinued. Nocturia in patients with marginal cardiac status and salt and fluid retention can be effectively controlled by limiting the time of administration to early afternoon. DIUTENSEN-R should not be used in patients with a known intolerance to reserpine. Package inserts furnish a complete summary of recommended cautions related to each of the ingredients of DIUTENSEN-R.


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Crash and Survive

THOMAS G. DICKINSON, M.D.

In 1964, 50,000 people met death in automobile accidents in the United States. In Florida alone, over 1,300 lives were lost from this cause. Review of the statistical trend of automobile fatalities over the past decade suggests that this figure will continue to increase. Table 1 demonstrates that the largest percentage of those killed is in the 15 to 25 year age group. Automobile fatalities present the highest cause of injury and death in our adolescent and young adult population.

Statistics suggest that almost all persons who drive automobiles either have been or will be involved in an accident during their driving career. The damage can vary from the simple street corner dented fender to the major highway fatality. The thesis of this communication is, therefore, not the prevention of accidents, for they will continue to occur, but that a large percentage of those killed on our highways could have survived the crash with relatively minor injuries.

It is a well recognized fact that the cars we drive reflect beautiful engineering and are well designed for unimpeded forward motion. It is equally well recognized by safety engineers, however, that the same car is in its most rudimentary stage of development as far as sudden deceleration is concerned. It has taken us 10 years to get two seat belts in our cars, and this is but the tiniest beginning (Campbell). It is our responsibility as

physicians and parents to take active measures to preserve the lives of those threatened by the skirmishes and scrimmages of the highway.

Preventive Measures

Of the two approaches to any problem of this nature, the first is accident prevention. We can instruct our younger generation to be technically competent handlers of automobiles; we can instruct them to keep their machines mechanically safe and free of structural failure. Drivers education courses can teach them defensive driving, or how to drive in anticipation of the other fellow's wrong moves as well as their own. They can be taught that, just as the best defense is a good offense, their car will stand out better as an object to be avoided by the other driver if the headlights are on during the daytime, especially while outside the city limits.

The two greatest causes of lethal accidents are first, speed, and second, alcohol. Drivers, particularly the young, while still malleable of mind, should be instructed to adhere to existing speed laws, to be alert at all times, and not to operate vehicles while they are under the influence of alcohol.

The second approach to the problem is to increase the chance of survival and to lessen the physical damage to the victim once he is involved in an accident. These objectives can be accom-

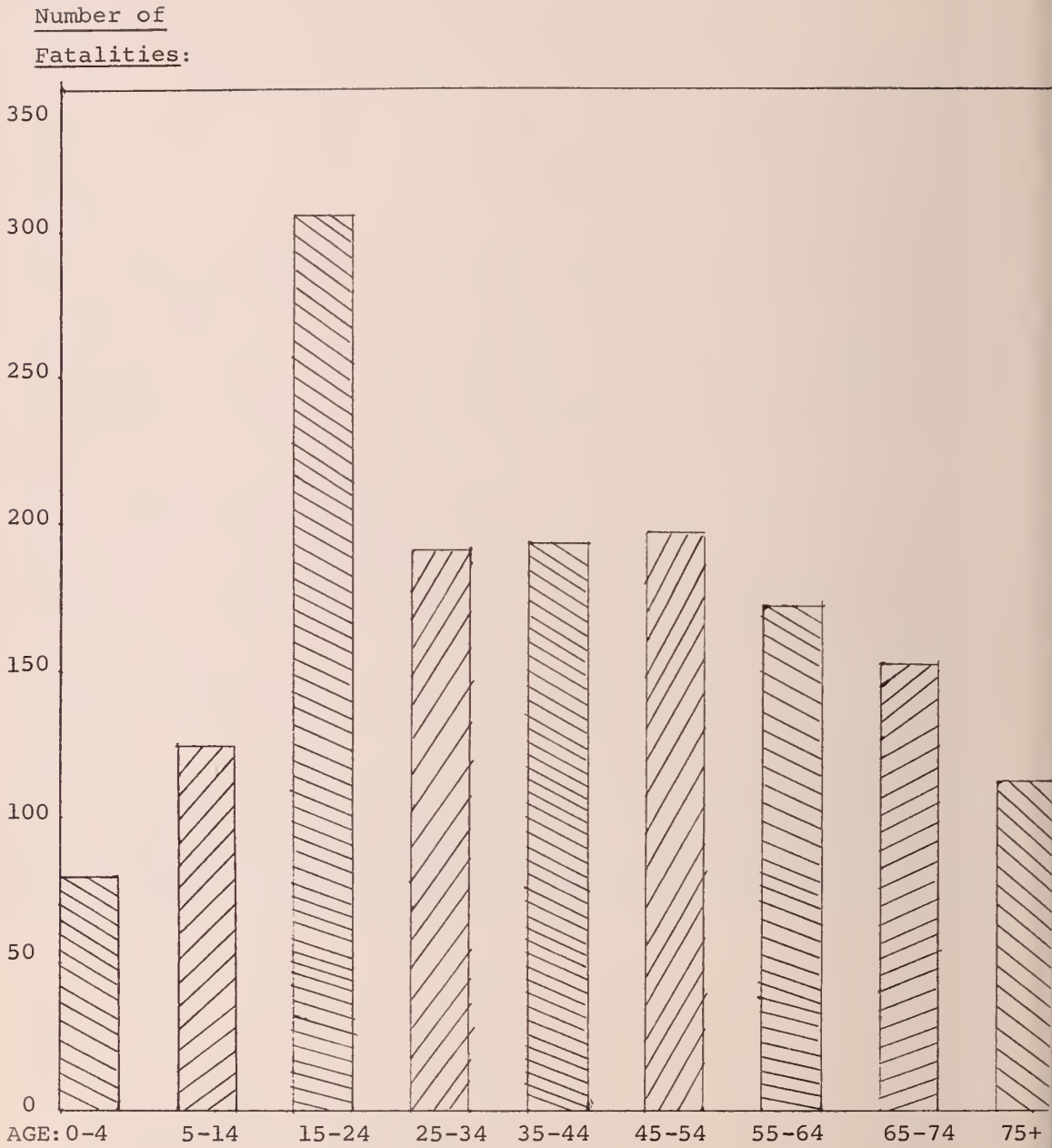


TABLE I

AUTO FATALITIES BY AGE GROUP: FLORIDA 1963

plished through the application of certain basic physical principles, and the incorporation of these principles into safety devices within the automobile.

The principle of packaging is helpful in this regard. The automobile accident may be divided into the primary accident, which is the collision of the automobile (the package) with the obstruction: a tree, another car, et cetera. The secondary accident, which is the collision of the passenger, you or I, with the package: the steering wheel, the instrument panel, the windshield, the frame, or some other protrusion within the car.

The principal source of injury comes from the deceleration of the passenger. Acceleration, positive or negative, is equal to change in speed divided by time; or

$$\text{Acceleration} = \frac{S^1 \text{ minus } S^2}{T}$$

If S^1 , or original speed, can be decreased, or the time can be increased, the forces imposed on the passenger will be less.

Deceleration would be harmless to our bodies were it not for the forces that can be imposed on the body thereby. It is not the acceleration as such that causes the damage, but it is a third factor, namely the change in acceleration, wherein the trouble begins. Change of acceleration is known as jolt. It is equal to the change in acceleration divided by the time, or distance over time cubed. This we can measure in terms of G forces. One G force stands for the weight of one gravity.

There are three critical factors in change of acceleration and the resultant forces applied to the body; namely, magnitude, direction and duration. If the magnitude of the G force is low, the forces can be withstood for a long period of time. It is the high G force of short duration, however, that causes the damage. It is the direction of the force on the individual, how much, how long, and over how wide an area, that is important.

Our mission, then, is to dilute these forces as much as possible by lessening their intensity, and by spreading the remaining force over as large an area of the body as we can. The following formula will make these G forces more meaningful (Campbell).

$$G = \frac{(\text{Miles per hour})^2}{30 \times \text{stopping distance in feet}}$$

Table 2.—Application of Formula

$G = \frac{(\text{Miles Per Hour})^2}{30 \times \text{stopping distance in feet}}$			
Stopping Distance Two Feet			
G at 10 mph =	$\frac{(10)^2}{30 \times 2} = \frac{100}{60}$	= 1.7	G
G at 30 mph =	$\frac{(30)^2}{30 \times 2} = \frac{900}{60}$	= 15	G
G at 60 mph =	$\frac{(60)^2}{30 \times 2} = \frac{3600}{60}$	= 60	G
Triple Stopping Distance to Six Feet			
G at 10 mph =	$\frac{(10)^2}{30 \times 6} = \frac{100}{180}$	= 0.5	G
G at 30 mph =	$\frac{(30)^2}{30 \times 6} = \frac{900}{180}$	= 5	G
G at 60 mph =	$\frac{(60)^2}{30 \times 6} = \frac{3600}{180}$	= 20	G
Realistic Stopping Distance of Passenger in Package about Two Inches, or 1/6 Foot			
G at 10 mph =	$\frac{(10)^2}{30 \times 1/6} = \frac{100}{5}$	= 20	G
G at 30 mph =	$\frac{(30)^2}{30 \times 1/6} = \frac{900}{5}$	= 180	G
G at 60 mph =	$\frac{(60)^2}{30 \times 1/6} = \frac{3600}{5}$	= 720	G

Table 2 shows the application of this formula to some theoretical highway situations.

At 10 mph with a two-foot stopping distance, G forces are only about 1.7, which is easily tolerated. At 30 mph with a two-foot stopping distance, the G forces would still be only 15, which could be tolerated with adequate seat and shoulder harness. At 30 mph, if the stopping distance is increased to six feet, the G forces are reduced to 5.

In applying this formula, we are referring to the passenger within the package. The critical factor is not how fast you stop, but how far you move after you begin to stop. Postulate that a car going 30 mph strikes a bridge abutment and has a stopping distance of two feet. The car then sustains a blow of 15 G and is exerting a force against the bridge abutment of 15 times the weight of the car. If the car weighs 3,000 pounds, this is a force of 45,000 pounds, or 22½ tons.

But what about the people in the car, the passenger in the package? The right seat passenger is about two feet from the forward structures, and the driver less than that from the steering wheel. The passenger reaches the structures when they have come to a rest. By the deformation of these structures, we may postulate stopping distance of perhaps two inches for the passenger, and possibly a little bit more for the driver. A stopping

distance of two inches is one-sixth of a foot, and in the formula the passenger in the right front seat sustains a force of 180 G. Now take, for instance, a girl weighing 100 pounds. At the moment of impact, the force would be 18,000 pounds, or nine tons, and all of it would be concentrated about the face. Viewed in that light, I am amazed that the accident death toll is not even higher. Table 3 illustrates the principal cause of death or severe injury to those in the front seat of an automobile involved in an accident (Campbell).

Table 3.—Per Cent of Occupants Having Serious or Fatal Injuries to a Body Area (Starks)

Area	Driver	Passenger
Head	57	65
Neck	8	12
Chest	33	18
Abdomen	12	11
Arms	0	0
Legs	2	4

Figures 1 through 5 illustrate an actual highway application of this formula. In figure 1, the driver, the only person in the car on the left, was fatally injured. Two persons in the car on the right survived. The car on the left weighed approximately 2,800 pounds, the car on the right approximately 3,800 pounds. The skid marks indicated that the lighter car came to an abrupt stop whereas the car on the right, slightly heavier, moved a few additional feet before coming to a halt. Figure 3 shows that the heavier car absorbed more impact through deformation of the forward structures than the lighter car, shown in figures 2 and 4. Seat belts were not in use in either car. In figure 5, the interior of the lighter car shows a deep dent in the lightly padded sun visor.

The formula $F = MA$, or force equals mass times acceleration, suggests that with a heavy car there are more forces to be dissipated and potentially, more forces reach the driver. Most automobile accidents, however, involve collision with another automobile, and in these cases, the car with the most mass, the most force, usually emerges as the less damaged. You do not match a lightweight with a heavyweight and expect to win.

The cause of death to the victim, a 225-pound man, was a large, compound comminuted

fracture of the skull that occurred upon impact of the head with the padded sun visor (fig. 5). Both cars were traveling approximately 40 mph at the time of head-on impact. The stopping distance of the lighter car (package) was approximately three feet. The stopping distance of the passenger within the package, upon impact of the sun visor, was approximately one foot. Applying these figures to the formula, we find that the victim struck the visor with a force of 53 G. One G for this victim is 225 pounds (body weight). The 53 G is equivalent to a force of approximately 12,000 pounds, or six tons. When analyzed in this manner, the fatality does not come as a surprise.

The problem is a simple one. In an accident, the automobile either stops suddenly or changes direction suddenly—jolt. The driver or passenger continues in the original direction at the original speed until he hits something. He will hit it at roughly the speed at which the automobile was moving when the accident began.

A boxer who can swing his fist at 19 mph can knock an opponent unconscious with one blow. It is therefore easy to imagine the consequences of a crash at even a modest 30 mph with the passenger flying around inside the package.

If we ship a dozen eggs by freight or mail, they are wrapped and packaged in such a way that they will arrive unbroken. There is no reason why the same amount of care and thought should not be given to protecting properly or packaging the passengers in a motor car to help them arrive unbroken.

Basic Safety Devices

We as individuals, as physicians, and as parents, can, for a very reasonable figure, install some basic safety devices in the cars that we ourselves, and even more important, our teenage children, drive. These will reduce the hazard of death and severe injury by approximately 75%. Our efforts must be aimed at: (1) restraining the passenger within the package to prevent, if possible, contact with protrusions within the package; (2) increasing the distance through which the victim moves once he has begun to stop; and (3) distributing the forces applied to the body over the widest possible area of the body and the least vulnerable area of the body.



Figure 1



Figure 2



Figure 3



Figure 4



Figure 5



Fig. 6.—Modified interior of a Los Angeles Freeway Patrol car.

Figure 6 shows the modified interior of the type of car used by the Los Angeles Freeway Patrol. The modifications make it possible for the driver of such a car to survive, uninjured, accidents involving speeds of a mile a minute.

The first and most basic aid is the restraining device. The many different types of harness on the market may be classified into four groups: (1) the simple lap belt; (2) the single diagonal shoulder belt; (3) the combined lap belt and single diagonal shoulder belt; and (4) the full or suspender harness. The attachment points are to the floor or to the door pillar.

The simple lap belt, although helpful, is nowhere near adequate because it allows the head, face and torso, hinging at the hips, to move forward to a secondary collision with the steering wheel, instrument panel, and the many obstructions thereon, as illustrated in figure 7.

The lap strap and diagonal chest strap model, floor-anchored, is an improvement, but transmits a jolt to the top of the shoulders which can cause fractures of the collarbone and compression fractures of the spine.

The diagonal chest strap and lap strap model, doorpost-anchored, is significantly better, in that the average forward motion (obtained by testing dummies in collisions) with the doorpost-anchored models is only 55% of that obtained with the floor-anchored models. In other words, it reduces the forward motion of the passengers by one half. The two shoulder suspender type harness, such as is used in aircraft, is even more superior,

but lends itself to some technical difficulties in installation in the front seat (figs. 8 and 9).

Hence, by the use of the combined diagonal shoulder harness and lap belt, once the vehicle has stopped in the primary collision, the passenger moves forward, headed for the secondary collision. He is restrained by this harness, and the pressures of this restraint are applied to the chest and hips with broad two inch belts. Three inch belts would be even better.

If the belts or their anchoring devices break, and not infrequently the forces applied are sufficient to break them, the speed of the passenger toward the interior of the package has already been broken somewhat (S_1 decreased in formula). If he moves forward to engage the instrument panel, heavy padding with at least two inches of resilient plastic or rubber will accomplish spreading the forces applied to the victim over a broader area, and will increase the stopping distance by at least two more inches, thus further diluting the forces (T in formula increased).

Pressure equals force divided by area. Pressure applied to the victim can therefore be decreased by decreasing the "F" and/or by increas-



Fig. 7.—Inadequacy of simple lap belt.

ing the "A" in the formula. F is decreased by increasing the stopping distance, and A is increased by the use of shoulder and lap straps, and by resilient padding on the point of contact. Structural provisions within the car should be such as to reduce the impact and distribute the pressures that are applied to the passenger in his secondary

collision with the package over as broad an area as possible.

Figure 10 shows a teenage girl passenger involved in an accident. The car had no restraining devices and no resilient padding. The primary accident did not injure her, but the secondary accident, that of the passenger with the package, accomplished this result in a matter of micro-seconds.

Measures that can be taken are:

1. Install crash-absorbent front structures. Bumpers on cars today are nearly worthless as energy-absorbing mechanisms. The result is that the frame structure and the engine block are called upon to do most of the energy-absorbing, and the engine may move back into the front seat. The application of malleable iron or aluminum foam to form the front structures of the car would go a long way to accomplish energy absorption.

2. Increase the structural strength of the package by use of a roll bar. Those of you who have attended stock car races have seen many crashes and few, if any, injuries. Each of these machines is equipped with a roll bar that will support the weight of the vehicle should it become



Figs. 8-9.—Utilization of doorpost-anchored diagonal chest strap and lap strap.



Fig. 10.—Secondary accident damage to teenage girl passenger; the car had no restraining device or resilient padding.

inverted. This also serves as an excellent fastening structure for the anchoring of the diagonal shoulder harness.

3. At least two inches of resilient protective foam padding should be applied to the instrument panel on the passenger's side, and to the windshield frame above and the front door post where possible.

4. Install safety glass. If the passenger strikes the glass, the chance of injury is high. The injury, however, is greater with the laminated type

of safety glass than it is with case-hardened or toughened glass, which is treated in such a way that the surface layers have increased resistance to fractures but which, when fractured, break into small fragments with relatively rounded edges. Ideally, the windshield should be held so that it comes out of its rubber mountings if sufficient load is applied to it. This type is called a "pop-out" windshield.

5. Purchase safety helmets, or, as they are commonly called, "hard hats." Most of the seri-



Figs. 11-14.—A roll bar box-welded to the car frame will support the weight of the car should it become inverted.

ous or fatal injuries caused by automobile accidents are to the head, 57% in drivers and 65% in passengers (table 3). Appropriate psychological programing could well bring effective helmets to be the "in" thing with the automobile driver, particularly when driving outside the city limits where greater speeds may be obtained. A report from Purdue University stated, "If the American motorist would adopt a safe type of headgear, close to 10,000 people could be saved annually from death or permanent brain damage caused by automobile accidents." All of the victims of the last five traffic fatalities admitted to Sarasota Memorial Hospital died of head injuries. There is an excellent chance that these five would be living had the use of that simple protective device, the hard hat, been employed.

For my teenage children to drive I chose a Checker station wagon, manufactured by the Checker Motor Car Co., Kalamazoo, Mich. It is equipped with the factory-offered option of heavy

duty springs and shock absorbers and 8-ply tires, to increase its manageability and safety at highway speeds. I selected this car because it has a relatively small engine with a relatively heavy frame. It has adequate power, but does not reach the suicidal top speeds attained by some vehicles, nor the death-defying acceleration obtained by the modern sports car. This car, upon delivery, was modified in the following ways:

1. A roll bar made of $1\frac{1}{2}$ inch galvanized pipe was box-welded into the frame. This bar

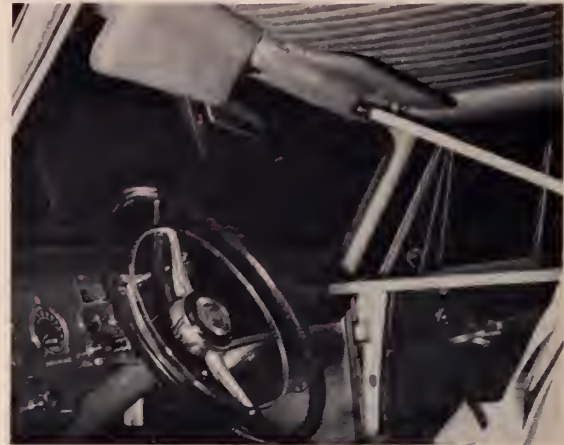
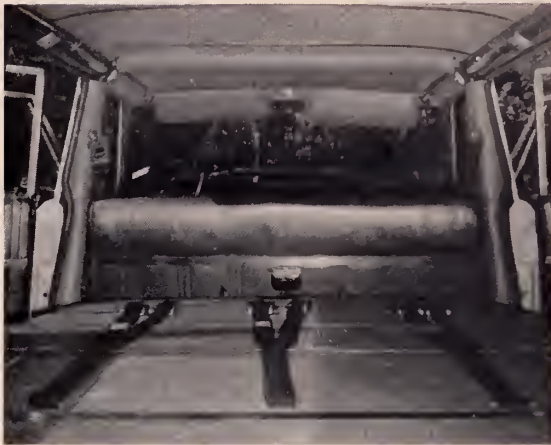


Figs. 15-16.—Structural steel bar designed to bend rather than shatter is secured to frame immediately behind front bumper. This bar is designed to absorb shock.

Figs. 17-18.—Combination diagonal shoulder harness and lap belts.



Figs. 19-20.—Suspender type shoulder harness installed in back seat.



Figs. 21-22.—Dashboard, windshield frame, roll bar and overhead structures padded with resilient plastic foam. Crutch arms demonstrate indentation resilience.



Fig. 23.—Stylish and well designed safety hats are now available.

Table 4.—Cost of Modifications

Materials		
Seat belts and rear shoulder harness (3)	\$25.00	
Swedish Volvo front seat combination lap and shoulder harness (2)	40.00	
Impact-absorbing bumper	30.00	
		\$ 95.00
Labor		
Installation of roll bar, harness anchors and impact-absorbing front bumper	\$150.00	
Redesigning impact-absorbing upholstery to cover roll bar, dashboard, etc.	275.00	
		425.00
TOTAL		\$520.00

will support the weight of the car inverted (figs. 11-14).

2. A structural steel bar, designed to bend, not shatter, upon impact, was secured to the frame immediately behind the car's original front bumper. It is designed to absorb some of the force of impact before reaching the passenger within the package (figs. 15 and 16).*

3. Combination diagonal shoulder harness and lap belts have been installed in the front seat. These are secured to the roll bar (figs. 8, 9, 17 and 18).**

4. Suspender type shoulder harness has been installed for three passengers in the back seat, secured to a $\frac{1}{4}$ " steel plate bar which is welded to the cross member in the frame, in addition to simple lap belts similarly secured (figs. 19 and 20).***

5. Dashboard, windshield frame, roll bar and overhead structures have been padded with at least two inches of resilient plastic foam**** (figs. 21 and 22). In figure 22, the two crutch arms indenting the foam serve to demonstrate the indentation resilience.

Table 4 shows the total cost of these modifications. This was a pilot project and many of the procedures had to be repeated two or three times. It is estimated that the cost could be cut by at least one quarter, and probably one third, on subsequent projects by the elimination of reduplication of labors involved.

Stylish and well designed hard hats are now available. The drivers of this car are provided with these hats, and instructed in their use. Figure 23 illustrates the style of some of the hats currently available. I urge that their use be popularized through all mass media.*****

One frequently hears it said, "They ought to do something about making cars safer." No one designates to whom the pronoun "they" refers. I submit that we are they. It can be done.

References are available from the author upon request.

► Dr. Dickinson, 1880 Arlington Street, Sarasota 33580

*Manufactured by Perry Co., Box 7187, Waco, Tex. Available through Anderson Ford, Inc., Sarasota, Fla.

**Manufactured by the Volvo Automobile Co., Sweden. Available through Parrish Motor Co., Jacksonville, Fla. Listed as part #277471. This is designed for bucket type seats, but can be easily modified to work with the bench type front seat.

***Available through Rupert Safety Belts, Rupert Parachute Co., Wheeling, Ill.

****Ensolite Type AH, U. S. Rubber Co., Mishawaka, Ind.

*****Bucro Helmet Hats are available through Jos. Buegeleisen, Inc., Box 1065, Southfield, Mich.

Ronnel in Creeping Eruption

J. E. BALTHROP, M.D.

Creeping eruption or larva migrans is a dermatitis characterized by twisting, unpredictable, inflammatory trails of larvae moving about in the skin. These trails in the skin are the result of an inflammatory response to the intracutaneous migration of the larvae of nematodes, the most common being that of the dog hookworm, *Ancylostoma braziliense*.

The parent nematodes mate in the bowel of the host animal and ova are deposited in the lumen of the bowel of the host to be eliminated in the stool. If the stool is deposited on wet, warm and sandy soil, the hookworm ova hatch and the larvae emerge. The human victim, by sitting, or lying or walking on the sandy soil, allows the larvae to come into contact with the skin and the epidermis is penetrated to the layer of the stratum granulosum (ground itch). Then, between the stratum granulosum and the dermis, the larvae tunnel and migrate, unable or unwilling to penetrate blood vessels. Thus they fail to complete the normal life cycle of the hookworm and are doomed, like The Man Without a Country of Edward Everett Hale, to wander aimlessly and without purpose until death overtakes them. This outcome has been estimated as taking from one to two months.¹

Treatment of creeping eruption in the past has been largely unsuccessful, as reference to any standard textbook of medicine will demonstrate. Recent reviews of the literature^{2,3} testify further to the absence of effective treatment. One new drug, however, thiabendazole, has been reported as being effective in the treatment of creeping eruption in a total of four cases.⁴⁻⁷

The purpose of this paper is to give a preliminary report of a treatment that seems to be sim-

ple, safe, easy and effective, in the hope that further studies in the use of Ronnel in this condition will be stimulated. Twenty-nine patients were treated with Ronnel easily, successfully and safely, and without serious or lasting complications.

Ronnel is an organic phosphorus insecticide manufactured by Pitman-Moore, Division of the Dow Chemical Company. It has not to date been released for human use by the Food and Drug Administration; but sold under the trade name of Ectoral, it has been extensively used by the veterinary profession for control of ectoparasites of dogs and cats. Pharmacologically it is a parasympathomimetic drug and gives with excess dosage the classical symptoms of acetylcholine poisoning: weakness, giddiness, blurred vision, headache, nausea, vomiting, abdominal cramps, diarrhea and dyspnea. Its antagonist is atropine.⁸

My interest in Ronnel was activated by a sense of helplessness in the face of patients with creeping eruption, and observation of the dramatic way that Ronnel freed dogs and cats of ticks. Correspondence was initiated by me with Pitman-Moore, from which, through the kindness of Dr. James T. Lowe, the following study resulted.

Analysis of Cases

Twenty-nine patients with creeping eruption were treated with Ronnel, four with a 20% ointment alone to the site of the eruption, four with the ointment followed by Ronnel by mouth and 21 by oral Ronnel alone. The ointment in the first four cases effected a cure, but the results in two cases were slow and equivocal (table 1). In the second four patients, Ronnel ointment was judged a failure after 25 days or longer and oral

Table 1.—Treatment of Creeping Eruption With Ronnel Ointment

Patients	Age	Weight	Number of Larvae	Days Treated	Results
1	6	56	1	30	Poor
2	5	50	10	7	Cure
3	1	30	30	30	Poor
4	2	40	4	5	Cure

Ronnel was administered with production of an immediate and effective cure (table 2). The remaining 21 patients were treated by oral Ronnel alone. In all cases the dose of the drug administered orally was calculated at 10 mg./Kg. daily for five days. It was given in three divided doses and with meals, with a dose of 250 mg. three times a day being the maximum dose for an adult weighing 150 pounds or heavier. Smaller doses were calculated proportionally. Seventeen of the 21 (81%) were cured in five days (table 3). Of the remaining four, two were cured with a repeated course of Ronnel, which brought the cure rate to 19 of 21 (90%). The remaining two seemingly were unaffected by treatment with Ronnel for a total of 10 days. Side effects were few (table 3) and did not require cessation of the drug. After the drug was discontinued, the side effects spontaneously disappeared.

During the course of treatment of creeping eruption with Ronnel, it was noted that a radical change was being effected in the natural history of the disease. Treatment by mouth was accompanied almost immediately or within 24 hours by stoppage of movement of the larvae and by cessation of itching. Especially was the marked discomfort in the heavy infestations relieved.

As the treatment progressed, four changes in the natural history of the disease were noted. In some of the patients, the majority, the track of the burrowing larvae simply disappeared. In others, the track disappeared, but a tiny pustule at the terminal end of each track remained. Drainage of the pustule in all such cases effected a cure. In one case the course of the tracks was

Table 3.—Treatment of Creeping Eruption With Ronnel

Patients	Age	Weight	Number of Larvae	Result after 5 Days	Side Effects
1	12	110	50	Cure	None
2	12	80	30	Cure	Nausea
3	9	70	5	Cure	None
4	8	60	1	Cure	None
5	7	60	4	Cure	None
6	12	80	3	Cure	None
7	10	60	10	Cure	Weakness, nausea
8	5	50	20	Poor*	None
9	11	71	Many	Cure	None
10	13	80	1	Cure	None
11	17	120	3	Cure	None
12	44	158	50	Poor*	Weakness
13	53	157	35	Cure	None
14	10	77	15	Cure	None
15	10	79	10	Cure	Serpiginous ulcers
16	17	107	5	Cure	None
17	10	70	15	Cure	None
18	7	47	36	Cure	None
19	13	129	6	Cure	None
20	13	130	10	Poor*	None
21	44	150	150?	Poor*	Weakness, blurring, nausea

*Retreatment for five additional days effected cure in two of four patients.

unroofed and a group of serpiginous ulcers uncovered. These ulcers healed slowly on treatment with an antibiotic ointment. In the severe heavy infestations, a wet macerated weeping lesion was produced which resembled eczematoid dermatitis and which necessitated constant warm compresses. Even in these last cases, cure was relatively rapid and without incident. No serious or permanent scarring was seen.

Summary

Ronnel was used in ointment form and orally to treat creeping eruption. The 20% Ronnel ointment was apparently without benefit in the treatment of this disease, but Ronnel by mouth effected a cure in 80% of cases in five days and 90% in 10 days.

Ronnel in creeping eruption altered the course of the lesions in one of four ways: (1) Larval trails disappeared. (2) Larval trails disappeared except for pustule formation at the end of the trails. (3) Larval trails were unroofed and serpiginous ulceration was produced. (4) Eczematoid dermatitis was produced. No serious or permanent side effects were experienced.

References are available from the author upon request.

► Dr. Balthrop, 25 West Avery Street, Pensacola 32501

Table 2.—Treatment of Creeping Eruption With Ronnel Ointment Followed by Ronnel Orally

Patients	Age	Weight	Number of Larvae	Ronnel Days Treated	Ronnel Orally for 5 Days	Side Effects
1	14	132	3	30	yes	None
2	7	52	5	25	yes	None
3	4	40	6	30	yes	None
4	7	70	1	27	yes	None

Current Thinking On Antidepressants

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Introduction and Clinical Overview of Antidepressants

Dr. Ainslie: Recently many new drugs have come into use for the treatment of emotional disturbances. Although drugs play only one part in the overall treatment of emotional disorders, their employment in treatment has had a great impact on the ultimate results. The three major groups of psychopharmacologic agents currently in use are the major tranquilizers (mainly phenothiazines), the minor tranquilizers (such as chlordiazepoxide [Librium] and meprobamate [Equanil]), and the antidepressants.

The antidepressants have been used experimentally and clinically for almost a decade, but their true effectiveness is still undetermined. Even when well controlled studies have revealed results favorable to the antidepressants, the difference between the efficacy of the drug and placebo has not always been great.

Several factors seem to contribute to the difficulty in assessing the effectiveness of the antidepressants:

(1) The natural course of most clinical depressions is spontaneous improvement and eventual recovery. For example, one report of a well controlled study on hospitalized depressed patients showed that 57% improved in two to six weeks, yet most of the available antidepressant drugs require one to three weeks to take full effect.

(2) The term depression may refer to a symptom, a syndrome, or a disease, and occurs in patients who differ in personality, sociocultural background and current situations. Patients may range from those of normal personality and background who are just unhappy, to those with inadequate personality and background who are suffering with severe, psychotic depression. In addition there is the acutely psychotic schizophrenic who may be depressed because of his frustration in attempting to interact meaningfully with his environment. This heterogeneous group of patients, therefore, cannot be expected to show a predictable uniform response to any kind of therapy.

(3) Satisfactory quantification of depression, either alone or in combination with other affects, emotions, and life situations, has not yet been achieved.

The physical treatments for depression are electroconvulsive therapy (ECT) and drugs. ECT is clearly effective in relieving severe depressions and is utilized by many psychiatrists, usually in a hospital setting. On the other hand, drugs can be used in any setting and by all physicians. It is their widespread use and occasional misuse which arouse concern about the clarity of the indications and the dangers inherent in the use of these potent agents.

The two major pharmacologic groups of antidepressants are the monoamine oxidase inhibitors and the imipramine-like compounds. Dr. Anton will describe their pharmacology later, but now I should like to review their clinical indications. The initial aim in the use of these drugs is the

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relief of intense disruptive emotion, so that the patient might more fully utilize resources within himself and his environment to achieve a more effective life. For example, feelings of depression, fatigue, and hopelessness may prevent the patient from getting well. The target symptoms, or clinical symptoms and signs, readily recognizable by every physician, constitute the first clinical criteria to be considered. The practitioner can rely on usual clinical techniques and observe the presence of sadness, slowness, irritability, and hopelessness in the history, speech and actions of a patient.

In our outpatient clinic we have recently shown the usefulness of antidepressant medication in patients selected solely on the basis of the target symptoms of depression. Table 1 shows a list of common symptoms and signs which were checked at each of seven weekly visits. The experimental design was double-blind and placebo-controlled. An initial, two week placebo period was used to avoid possible untoward effects of certain drug combinations. This procedure was discovered to eliminate most of the suggestibility-correlated placebo responses. It permitted us to achieve significant results with about one-half the number of patients which would otherwise have

been required. Figure 1 shows the change in severity of the presenting symptoms relative to the third visit, that is, the visit after the two weeks of placebo and just before the starting of the experimental double-blind period. (All the scores have been corrected for absolute differences at the third visit.) The data clearly demonstrate that in comparison to the placebo, imipramine (Tofranil) was very effective in relieving the target symptoms in these patients. Thus, target symptoms and signs are simple to identify and statistically reliable to use.

A more precise selection of medications can be made by taking into account the background of the patient, his characteristic ways of handling

Table 1.—Interviewer's Record of Signs and Symptoms

1. Date
2. Overactive or speeded up
3. Underactive or slowed down
4. Anxious or tense
5. Lack of interest, low in energy
6. Blue or depressed
7. Unusually happy
8. Afraid or fearful
9. Guilty
10. Irritable or easily angered
11. Impulses to hurt someone
12. Trouble controlling feelings
13. Loss of sexual interest or ability
14. Too much sexual interest or feeling
15. Loss of appetite
16. Increase of appetite
17. Not able to sleep enough—early awakening
18. Evening insomnia
19. Sleep too much
20. Trouble thinking or concentrating
21. Strange or upsetting thoughts
22. Muscles feel weak and tired or sore
23. Sudden involuntary jerking movements
24. Restless jitters, pacing, tapping
25. Trouble moving arms, legs or face
26. Trembling of hands
27. Blurred vision
28. Constipation
29. Diarrhea
30. Dopey or groggy
31. Dry mouth or dry throat
32. Faint or dizzy
33. Nauseated or vomiting
34. Lack of enjoyment during free time
35. Itching or skin rash
- 36.
- 37.
- 38.
- 39.
- 40.
41. Overall general status
42. Patient seems same, better, or worse than at last visit

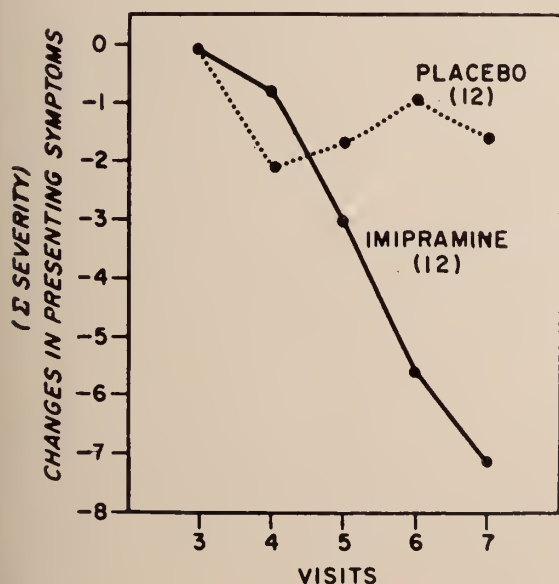


Fig. 1.—Comparative effectiveness of imipramine and placebo in depressed patients. The greater the negative number the more effective the agent was in relieving the target symptoms in these patients.

Item Scoring Key: 0 = Not at all; 1 = A little; 2 = Quite a bit; 3 = Very much

routine responsibilities and stresses, his relationship to his physician and to others such as his family, friends and employers, and his physiologic status. Also these bits of information define the matrix within which the patient's symptomatology occurs, and permit an evaluation as to the balance of forces at play which result in the target symptoms. The major symptoms alone can suggest one of several drugs, or a combination, but the dynamic situation determines the most appropriate selection if a drug be necessary at all.

A few clinical examples illustrate how target symptoms indicate the kind of drug to be selected and how a knowledge of the dynamic situation further refines the selection. It should be emphasized that in depression, as with other psychiatric problems, it is the underlying emotional problem which determines the choice of drugs:

(1) A male patient is depressed, tense and slow, but also demonstrates veiled anger at, and resentment of, his wife. To give him an antidepressant such as imipramine alone will often simply release energy which might result in violence directed outwardly towards his wife or inwardly towards himself. In this case a newer drug of the same class, amitriptyline (Elavil), which also appears to have a tranquilizing component in its effect, would be the drug of choice. If this is not sufficient to contain the mobilization of anger, then the simultaneous use of imipramine and a phenothiazine with minimal sedative properties, such as trifluoperazine (Stelazine), would be indicated. This combination could serve to decrease the intensity of the hostile feelings so that they would not be overwhelming. Then the hostility could be dealt with through environmental alteration or individual means while the depression was being relieved by the imipramine.

(2) In contrast, if a similarly depressed patient is seen without evidence of underlying hostility, then a phenothiazine would be

contraindicated as it would be likely to worsen the depression. An antidepressant of the monoamine oxidase inhibitor type, such as nialamide (Niamid) or phenelzine (Nardil), or of another type such as imipramine would be indicated in addition to emotional support from the physician. This combination would aim to increase the patient's sense of worth through the physician's demonstrated interest.

(3) A third example is a patient whose depression seems to be due almost entirely to angry resentment, handled by suppression. Here the use of a phenothiazine alone, plus adequate measures to deal with both the sources of anger and the means for its appropriate expression, would be indicated.

Which is the drug of choice for depression? This depends upon the nature of the drug, the severity of the symptoms, the underlying emotional problem, and the situation. A review completed six months ago indicates that imipramine is quite effective; tranylcypromine (Parnate) is comparable, while the newer drug, amitriptyline may be superior to both. All seemed somewhat superior to phenelzine. The effective speed of onset of action also should be considered. Thus, as indicated in table 2, this can range from five to seven days in the case of tranylcypromine to 14 to 21 days with phenelzine. It should be mentioned, however, that tranylcypromine also has an immediate Dexedrine-like effect which may be desirable with some patients.

Also, drug-related side effects and complications must be considered. The MAO inhibitors, especially tranylcypromine, have the potential of severe, though rare, hypertensive crises precipitated by pressor amines in drugs or food. The adverse effects of the MAO inhibitors now in use are not serious and include a mild blood pressure drop, restlessness, and insomnia. Imipramine may cause undesirable psychic-stimulating effects, acute hypotension in elderly patients, and the annoying

Table 2.—Comparative Speed of Onset of Antidepressant Action in Humans

DRUG	DAYS
TRANLYCYPROMINE (PARNATE)	5 - 7
IMIPRAMINE (TOFRANIL)	10 - 14
PHENELZINE (NARDIL)	14 - 21

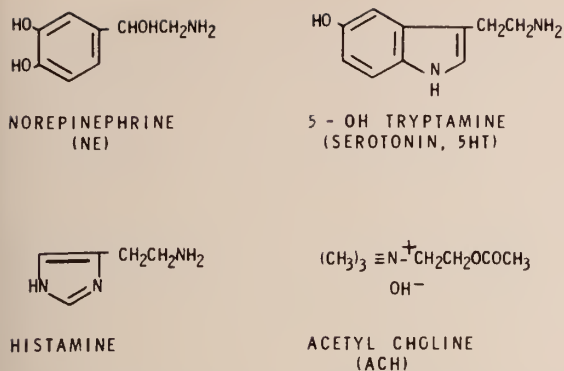


Fig. 2.—Formulae of compounds currently considered as neurohumoral agents in the central nervous system.

In figure 2 are shown those substances which have been postulated as subserving a role as a mediator or modulator of synaptic transmission in the CNS. That there may be other such substances in brain is indicated by the x. By definition, however, electrolytes, carbohydrates, proteins, polypeptides, vitamins, cofactors and other nutrients are excluded from this discussion even though they are necessary for normal brain function. It should be noted that the substances in figure 2 are all amines in which the decarboxylation of a naturally occurring amino acid occurs at one step in the biosynthetic pathway (tyrosine in the case of NE, tryptophane for 5HT, histamine from histidine and serine eventually gives rise to acetylcholine).

Historical Background

symptoms of dry mouth, perspiration, tremor, and sedation. With amitriptyline the serious psychic and cardiovascular side effects seem less likely to occur.

As with all drugs, it is best for the physician to use those few with which he is most familiar. For example, I use phenelzine which has minimal side effects, if a delay of three weeks in onset of action is clinically permissible. I use tranlycypromine, however, for its immediate Dexedrine-like effect followed by a relatively rapid true antidepressant effect if the patient's condition warrants this approach. Finally, I prefer imipramine because I am most familiar with this drug, in terms of dosage, side effects, and how it can be combined with phenothiazines and sedatives. Also, it appears to be the most useful of the antidepressants.

(Dr. Stiefel presented an illustrative case report.)

The Pharmacology of Antidepressants

Dr. Anton: Now that you have heard about the clinical use of the antidepressants, I would like to discuss their pharmacology in terms of a possible mechanism of action. The thesis I intend to develop is that the effect of these agents may be due to an interference with the functional integrity of norepinephrine (NE) and/or serotonin (5HT). These are two normally occurring neurohumors believed to be involved in synaptic transmission in the central nervous system (CNS).

It has been only about 10 years since the following four observations were made which formed the basis for the concept of a possible biochemical lesion as the cause of certain mental diseases:

(1) NE and 5HT, two naturally occurring amines with marked peripheral and central effects, were found in the brains of animals, and their distribution, together with their metabolic enzymes, implied a functional rather than an architectural role.

(2) Lysergic acid diethylamide (fig. 4), one of the most potent psychotomimetic agents known, is an analogue of 5HT and is a highly active antagonist to 5HT in certain biologic test systems in vitro.

(3) Reserpine (fig. 4), one of the first tranquilizers used in psychiatry, was found to deplete NE and 5HT from the CNS of many different species of animals. Furthermore, only those analogues which had this action were tranquilizers.

(4) Iproniazid (fig. 3), the first useful antidepressant, was found to inhibit brain monoamine oxidase (MAO), which is one of the enzymes concerned with the degradation of endogenous NE and 5HT. As a consequence of this inhibition a significant increase in NE and 5HT in the CNS is obtained in some animals.

From these observations there evolved the field of psychopharmacology, which spawned a

whole new family of drugs as well as a monumental amount of research and literature which has attempted to elucidate how these drugs work.

Classification of the Antidepressants

The antidepressants can be divided into two main classes: (1) those that inhibit MAO, and (2) those that do not have this potential.

This terminology implies that there is a direct cause and effect relationship between the ability of some of these agents to inhibit MAO and their antidepressant action. Whether this is how some of these drugs work still has to be proven. The present evidence, however, is highly suggestive of a causal relationship.

The MAO inhibitors are further subdivided into hydrazine and nonhydrazine types and into long-acting and short-acting agents. Only certain of the long-acting ones are in current use.

Examples of the various types of antidepressants are shown in figure 3 and certain characteristics may be emphasized from a structure-action relationship. The long-acting, noncompetitive MAO inhibitors, iproniazid, phenelzine and tranlycypromine as well as the neurohumor, nor-epinephrine, are derivatives of phenylalkylamine, and thus are analogues (pargyline [Eutonyl] also is in this category). Amphetamine, also a phenylalkylamine, was used at one time as an antidepressant, and originally was thought to act by virtue of being a MAO inhibitor. It is, however, very weak in this respect and such an action would be negligible at the doses used in man. Nevertheless, the present evidence suggests that the amphetamines, like a number of other sympathomimetics, exert an effect by activating NE through displacement from storage sites where it is bound in an inactive form. (Methylphenidate

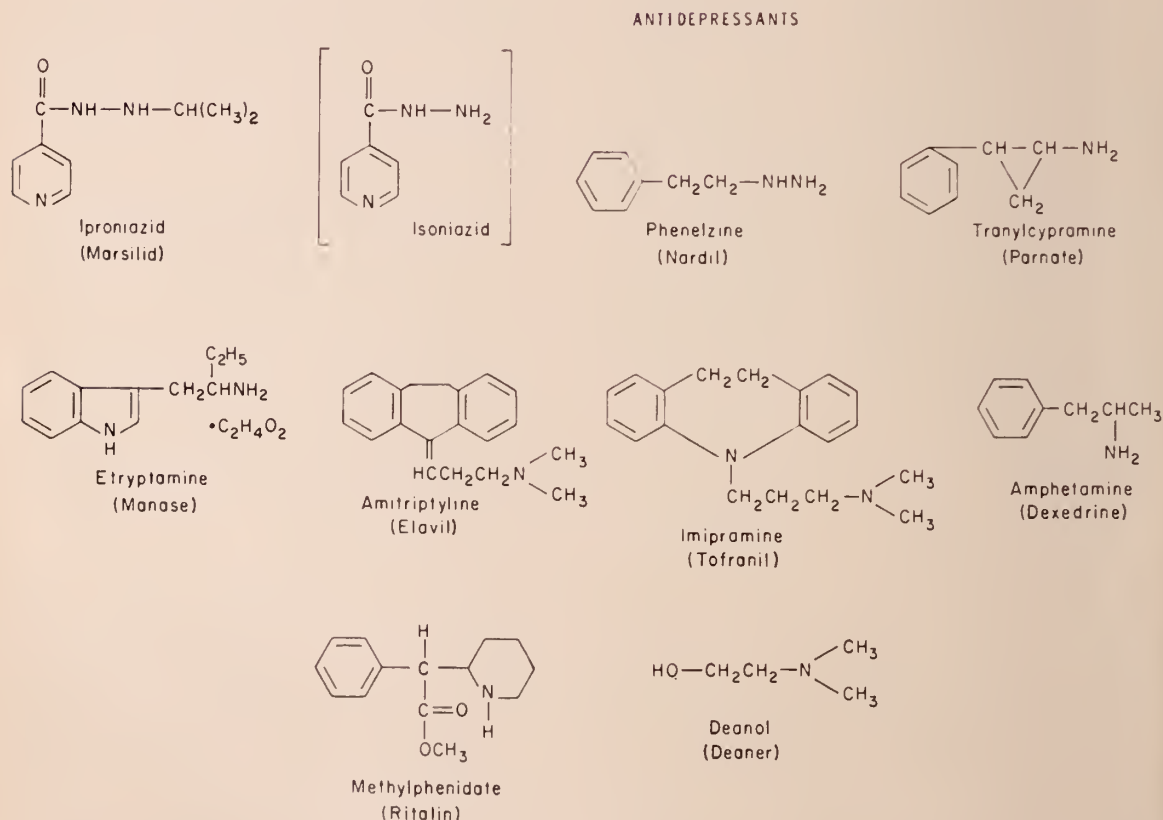


Fig. 3.—Formulae of representatives of the several classes of antidepressants. Isoniazid is in parentheses because it is not an antidepressant, but is included because it is an analogue of iproniazid.

also is in this category.) Etryptamine, a short-acting, reversible MAO inhibitor (no longer used), is the only indole derivative among the antidepressants and is structurally related to serotonin. Amitriptyline and imipramine are antidepressants which do not inhibit MAO, and are more structurally related to the tranquilizer, chlorpromazine (fig. 4) than to the phenylalkylamine antidepressants. This may explain their apparent greater effectiveness in those depressions which also require some tranquilization. That an aromatic nucleus is not necessary for antidepressant activity is shown by the drug deanol (fig. 3, no longer in use), which is structurally related to acetylcholine. A number of other interesting psychopharmacologic agents (some of which will be mentioned in this discussion) also are shown in figure 4. Note that most of these compounds are

structurally related to NE or 5HT since they have either a phenylalkylamine or an indole nucleus. This can be considered as additional circumstantial evidence that these compounds may exert a central effect by modifying in some manner the function of NE and 5HT in the CNS.

Hydrazine-Type MAO Inhibitors

The use of iproniazid as the first effective antidepressant resulted from a chance observation. About 10 years ago iproniazid was introduced for the treatment of tuberculosis. At first it was thought that a cure for TB had been found, since bedridden patients were up and around soon after starting treatment with iproniazid. It was soon realized, however, that it was the CNS-stimulating effect of the drug rather than its TB-curative

PSYCHOPHARMACOLOGIC AGENTS

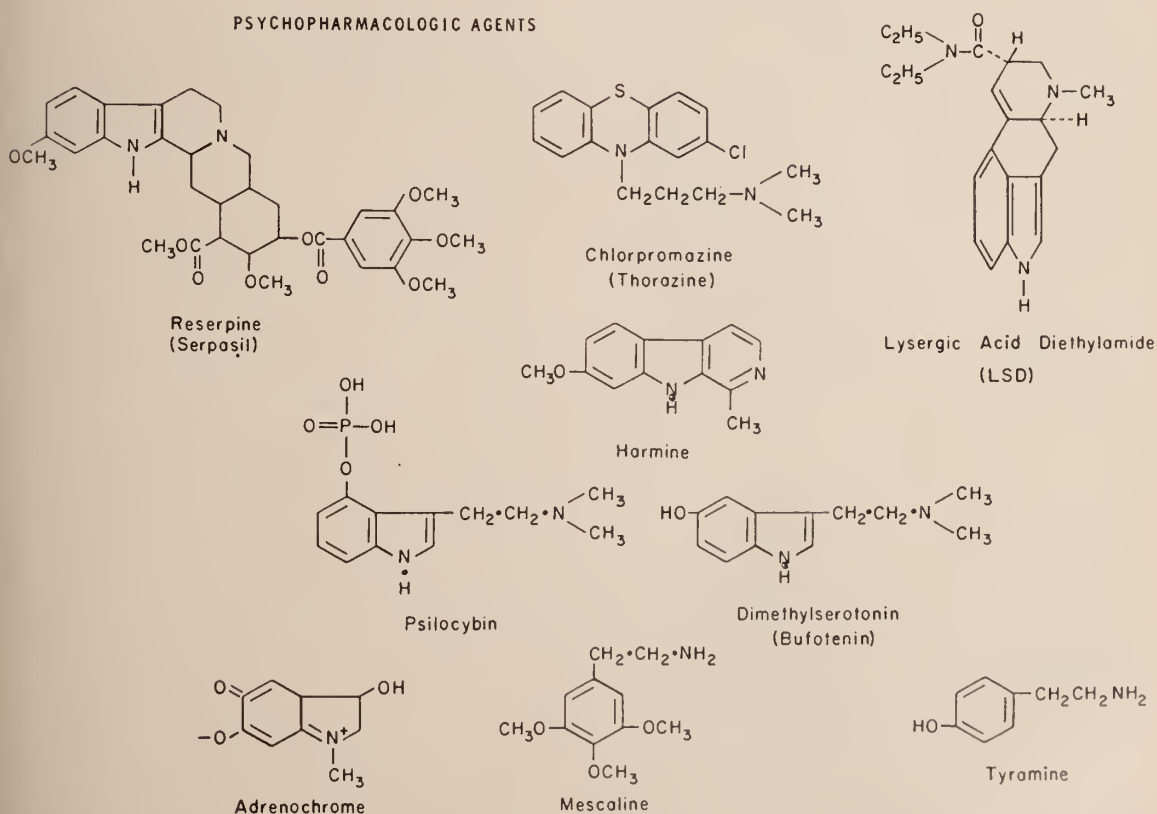


Fig. 4.—Formulae of several clinical as well as experimental psychopharmacologic agents of current interest.

Table 3.—Doses (in μ moles/kg. i.p.) for 50 per cent Enzyme Inhibition in Rat Brain In Vivo+

Compound	Monoamine Oxidase	Aromatic Amino Acid Decarboxylase
Tranylcypromine	7 (6-7)	No inhibition*
Pargyline	-	No inhibition*
Benzylhydrazine	5 (5-6)	500
Pheniprazine	6 (5-6)	315 (270-360)
Iproniazid	39 (29-44)	No inhibition*
Isoniazid	No inhibition*	1200 (900-1500)
Ro 4-4602	No inhibition*	42 (30-65)

+After Gey et al., 1963, courtesy of Ann. N. Y. Acad. Sci. 107: 1147.

*No significant effect by sublethal doses (500-3000 μ moles/kg.)

property that made the patients feel so good. The possibility of using this drug in the treatment of depressions was soon realized and it began to be used extensively in psychiatry. Studies on the nature of this effect revealed that although MAO was only one of many enzymes inhibited, this antagonism occurred at a reasonable concentration of the drug.

Furthermore, since MAO was involved in the degradation of NE and 5HT, it was postulated that iproniazid acted by interfering with the metabolism of these amines in the brain. This assumption was partially borne out when it was found that the levels of NE and 5HT in the CNS of various species of animals increased significantly after the administration of the drug (fig. 7). Also, iproniazid was found to prevent the tranquilizing effect, as well as the amine-depleting action of reserpine. In fact, this relationship is one of the criteria for testing a drug for potential antidepressant activity. Thus, in figure 5A the sedated and tranquil appearance of a reserpinized rabbit (5 mg/kg I.V.) may be compared to the alert appearance of the other rabbit in figure 5B which had received iproniazid (100 mg/kg I.P.) 16 hours prior to the reserpine. A biochemical correlate of these different behavioral effects was the interesting finding that brain NE and 5HT were depleted in the tranquil rabbit but not in the alert animal. As a consequence of such studies, a large number of iproniazid-like drugs were made available to psychiatrists for the treatment of depression; one of these is phenelzine (fig. 3), a hydrazine derivative which apparently has less liver toxicity than iproniazid. The effect of these newer agents on brain NE and 5HT, and their reversal of reserpine tranquilization are similar to the response to iproniazid. Because of the classical work done with iproniazid, it is used as a model in this discussion.

Nonhydrazine Types

Initially, it was thought that the hydrazine moiety in the compound was essential for antidepressant activity. Because of the inherent reactivity and toxicity of the hydrazine radical,



Fig. 5.—Prevention of the tranquilizing effect of reserpine by an antidepressant. Both rabbits received reserpine (5 mg/kg I.V.), but rabbit "B" had been pretreated with iproniazid (100 mg/kg I.P.) 16 hours prior to the reserpine.

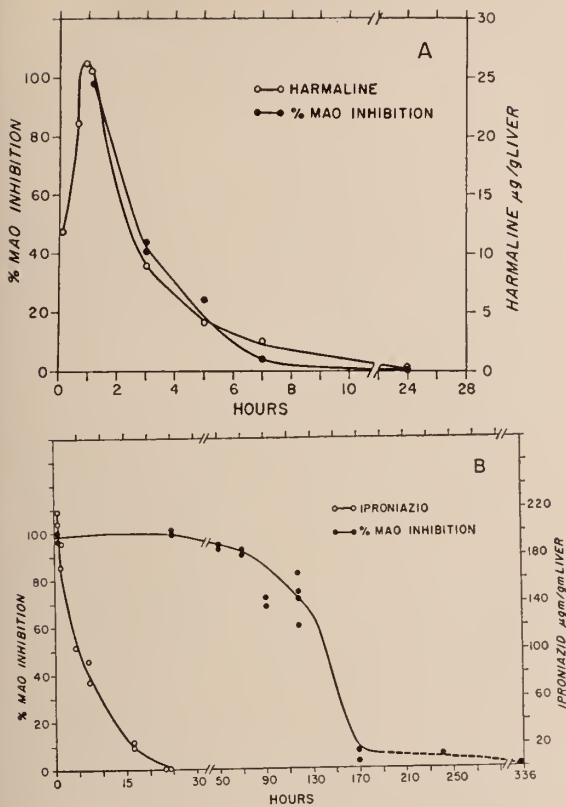


Fig. 6.—Tissue decay curves and duration of inhibition of monoamine oxidase by a reversible (A) and nonreversible (B) inhibitor in rat liver. (A after Udenfriend et al., 1958, courtesy of Biochemical Pharmacology; B, after Hess et al., 1958, courtesy of Journal of Pharmacology and Experimental Therapeutics).

however, attempts were made to develop similarly acting drugs but without the hydrazine radical. These attempts were successful with the introduction of tranlycypromine (fig. 3) and pargyline. Neither of these compounds is a hydrazine, but they are potent antidepressants as well as being potent MAO inhibitors. An important bit of circumstantial evidence for the connection between MAO inhibition and antidepressant activity was provided by these compounds, since not only do they inhibit fewer enzymes than their hydrazine analogues, but they are more active MAO inhibitors than iproniazid, and they cause NE and 5HT to accumulate in the CNS at lower doses. Furthermore, like the hydrazines, they reverse reserpine tranquilization.

Catechol-O-methyltransferase, cholinesterase, dopa decarboxylase and dopamine- β -oxidase are several of the enzymes which are not inhibited by

the anti-MAO compounds except at very high concentrations. An example of this selective activity is shown in table 3 where a number of compounds are compared for inhibition of rat brain MAO and aromatic amino acid decarboxylase. The first five compounds, consisting of hydrazines and nonhydrazines, inhibit MAO at concentrations which have no significant activity against the decarboxylase. Note that isoniazid (fig. 3), an analogue of iproniazid, has neither anti-MAO activity nor any use as an antidepressant in man. The last compound RO 4-4602, is a hydrazine-type decarboxylase inhibitor with no anti-MAO activity, indicating that not all hydrazines (at nontoxic concentrations) are inhibitors of MAO.

Long-Acting and Short-Acting MAO Inhibitors

A further classification of the MAO inhibitors divides them into long-acting irreversible, and short-acting competitive inhibitors of the enzyme. The availability of such inhibitors has allowed the demonstration of an important correlation between the pharmacologic and enzymologic effects of these agents which supports the thesis of a relationship between MAO inhibition and antidepressant activity of certain drugs. This is shown in figures 6A, 6B, and 7. In figures 6A and

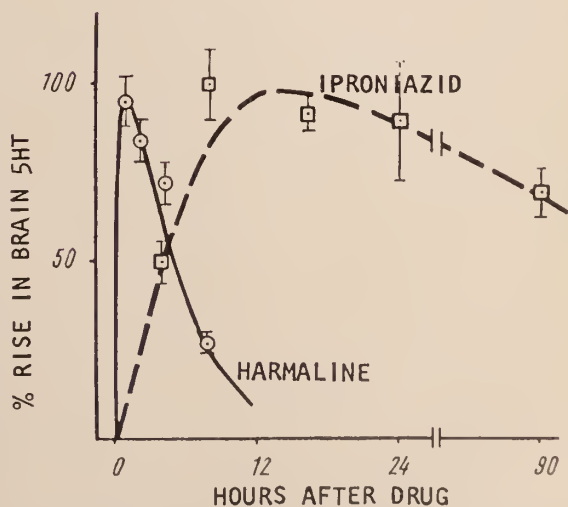


Fig. 7.—Increase in serotonin in rat brain after the administration of 30 mg/kg harmaline or 100 mg/kg iproniazid. Although not shown here, the per cent rise in norepinephrine is about half that of the serotonin. (After Pletscher et al., 1959, courtesy of Helvetica Physiologica Pharmacologica Acta.)

6B are compared the tissue decay curves and the duration of MAO activity of the long-acting, non-competitive inhibitor iproniazid, and the short-acting, competitive inhibitor harmaline (or harmine). (Etryptamine rather than harmaline was used in man, but these drugs [figs. 3 and 4] have certain pharmacologic properties in common.) In the case of iproniazid the inhibition of MAO does not parallel the tissue levels of the drug as it does with the reversible inhibitor.

Referring now to figure 7, it can be seen that the increase in brain 5HT (the increase in NE is about half that of 5HT) after the administration of these drugs follows the inhibition of MAO rather than the tissue levels of the drugs. This is readily apparent in the case of iproniazid since the inhibition of the enzyme does not coincide with the tissue levels of the drug as it does with harmaline. It also is pertinent that the use of these agents in man coincides with their anti-MAO action and not with their tissue decay curves. Thus, the effect of etryptamine is rapid in onset and of short duration after discontinuing the drug, whereas a delay in onset of action after the drug is started and persistence of effect after the drug is stopped occur with iproniazid. It is interesting that the prior administration of etryptamine will protect MAO against the persistent effects of iproniazid suggesting that both compounds attach to at least one similar site on the enzyme even though they are structurally unrelated (fig. 3).

A very disconcerting side effect recently reported with the MAO inhibitors has been the hypertensive crises in some patients who had ingested certain cheeses and wines while taking these drugs. This effect has been shown to be related to the tyramine content of these foods. Tyramine (fig. 4), which is a sympathomimetic

agent, is a good substrate for MAO. Thus, in the presence of the inhibitor the degradation of tyramine is blocked, resulting in a toxic accumulation of the amine, which precipitates a marked hypertensive reaction.

Non-MAO Antidepressants

Apparently MAO inhibition is not necessary for antidepressant activity since imipramine and amitriptyline (fig. 3) (as their monomethyl derivatives) are antidepressants and yet do not inhibit MAO. The pertinent point, however, about these agents is that they have been shown to affect the metabolism of NE and 5HT, apparently by interfering with the mechanism involved in the storage of these amines in an inactive form. Also, these agents, like the MAO inhibitors, have been found to prevent the reserpine syndrome in animals, but unlike the MAO inhibitors, they do not prevent the reserpine-induced depletion of the amines from the CNS.

In summary, evidence has been presented in support of the following three points: (1) There appears to be a suggestive relationship between antidepressant activity of a compound and an effect on brain norepinephrine and/or serotonin. (2) This relationship might be mediated through the inhibition of brain MAO by certain compounds. (3) The fact, however, that some antidepressants do not inhibit MAO, but do affect the function of norepinephrine and/or serotonin, suggests that a number of diverse drugs may exert an antidepressant activity through a common final neurochemical pathway.

References and reprints are available from the authors upon request.

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Erratum

The Journal of the Florida Medical Association regrets and wishes to correct an error appearing on page 637, column two, paragraph one, line six of the July 1966 issue. The portion of the paragraph in question should have read:

"... with the practice of medicine as we conceive it. We must keep the practice of medicine in the hands of physicians and not allow it to fall..."

Surgical Treatment Of Varicoceles

HERBERT J. LEVIN, M.D.

The problem of varicoceles in the military and other areas where the performance of one's duties can depend on a sense of well-being is a continuing problem. My associates and I have dealt with the problem by a surgical technique proposed by Paloma in 1949, and we have 40 successful cases to add to his original 40 in 38 patients. The surgical technique is a relatively simple procedure that takes 20 to 30 minutes for completion and includes ligation and transection of the internal spermatic artery and vein or veins retroperitoneally superior to the internal inguinal ring. The success rate for ridding the patient of the varicocele was 100%. As with Paloma's original 40 operations, we have not noted testicular atrophy in any of the patients.

Symptoms

Patients with varicoceles are difficult to evaluate because we have all seen patients with large varicoceles who are asymptomatic and others with small varicoceles who complain of varying symptoms in the scrotum and the inguinal regions. We personally have been convinced that varicoceles can be symptomatic because in all of our patients the symptoms were improved following the surgical procedure. Included in the series were one physician and several other officers who appeared to be well motivated. Most of the patients with symptoms complained of a dragging sensation and heaviness in the left side of the scrotum. Some complained of occasional pains in the left

inguinal region. The pains were usually of a nagging nature, but these who were subjected to heavy labor complained of occasional sharp pains in the scrotum and along the cord. The sharp pains would subside with rest, but a dull ache would continue until the patient had a longer period of rest. Most of these patients would admit to some improvement by wearing a scrotal support of some type, but the ones who were operated upon were not satisfied with the type of relief that the support gave them. Several of the patients had an accompanying mild epididymitis with specific tenderness to palpation over the part of the epididymis involved. One of these patients continues to complain of some scrotal pains post-operatively even though the dilated veins of the varicocele are no longer present.

It has been our impression that no greater preponderance of neurotic patients complain of symptoms from a varicocele than with any of the other urological problems. The great benefit of having something to offer the patient makes the entire problem much easier for the urologist since a cure can be offered. The neurotic patient who has some pain from the varicocele can refuse operation, but those patients who are sincere in their symptoms can have something substantial done for them, instead of being advised that this mass in the scrotum should not be bothersome. It is possible that some of the symptoms are aggravated by knowing the mass is present, and there are psychological implications to an abnormality in the scrotum, but this problem can be relieved by operation and one source of neurosis has been eliminated. If the patient then attacks other sys-

Read before the Southeastern Section of the American Urological Association Twenty-Ninth Annual Meeting, March 18, 1965.

tems of his body, at least the urologist has been spared.

Although we did not keep statistics on the total number of men who were seen because of the presence of a varicocele, it is our impression that operation was performed on no more than 20% of the specific referrals for varicocele. Some patients were referred for confirmation of the diagnosis, some for clearance for separation from the service, and others for advice. Those who were completely asymptomatic were merely examined and the findings recorded. Those who were mildly symptomatic were advised about wearing a scrotal support and told to return if their symptoms were not relieved. The real problems were those who complained of symptoms, had previously worn a scrotal support, and stated that they could not perform their duties because of pains in the scrotum when doing heavy work.

In the military, these patients can either be profiled and kept from performing their normal duties, be court-marshaled and dishonorably separated from the service, or have something done to relieve the cause of their discomforts. We were especially thankful to be able to perform a procedure for them that we knew would be effective. Our indications for surgical therapy, however, were not limited to the difficult administrative problems, but applied also to other patients such as the one physician who had had the varicocele from high school days, had mild chronic discomforts, and wanted something done so that he would not have similar problems throughout his entire lifetime.

Surgery

The history of suprascrotal ligation of the spermatic artery for the treatment of varicocele is not new. In 1901, Bennet of England performed over 200 varicocelectomies by ligating both the internal spermatic artery and the internal spermatic veins at the level of the external inguinal ring. He divided the entire spermatic bundle with the exception of the vas deferens and the artery with the vas. In 1911, Potter presented a paper before the Medical Society of Greater New York in which he reported 200 cases of varicocele treated by a suprascrotal operation with ligation of the spermatic artery and veins. He was able to follow 67 of his patients well and not one of them had atrophy of the testis.

In 1918, Ivanissevich and Gregorini advocated the high ligation of the internal spermatic vein with sparing of the artery and this line of thinking has continued to some extent. Riba reported 23 cases successfully treated by this method. In 1949, Paloma returned to ligation of both the internal spermatic vein and the spermatic artery which had been reported 58 years before by Bennet, but Paloma made his ligation above the internal inguinal ring where there was no danger of interfering with the artery with the vas. It was with the Paloma procedure that we have had our experience.

The operation has been performed by us in every instance with general anesthesia, but Paloma reported using local anesthesia. The incision has been a low lateral left-sided McBurney or Gibson type. The external oblique fascia is incised the entire length of the skin incision because the fascia is the most limiting structure for retraction. The muscles are separated bluntly with Kelly clamps and the peritoneum brushed medially. One will then find the spermatic vein or veins and the spermatic artery coursing toward the internal inguinal ring. The vessels will be in their own fascial bundle and adherent to the posterior peritoneum so that the vessels will have to be bluntly separated from the peritoneum. This procedure is not difficult to accomplish but, on one occasion, the peritoneum was entered. It was closed and the patient had the usual postoperative course.

The vessels are dissected free from the surrounding soft tissue and double-clamped, most easily with right angle clamps. No attempt is made to identify the spermatic artery, but the entire bundle is clamped and the artery is included. The cord between the clamps is transected and the free ends tied. We have had no problems with postoperative bleeding and drains have not been necessary. The muscles and fascia are then approximated. We have been using skin clips for the skin approximation, which allow the patient to be discharged from the hospital by the fourth or fifth postoperative day. We have had no postoperative surgical complications.

The level of the skin incision is not important as long as one clamps the cord above the entrance of the vas deferens with its artery. When the skin incision was made as described, the vas was only identified in one of the 40 operations. Some of our original difficulties with the procedure were in dissecting too far posteriorly behind the peritone-

um, but the cord in the region of the incision is superficial. One frequently gets a faint glimpse of the bluish vein attached to the peritoneum and dissection in that region will disclose the enlarged vein or veins with the artery attached to but not part of the peritoneum.

Blood Supply to the Testis

The greatest concern with this procedure is the arterial blood supply to the testis and the possibility of atrophy of the testis with decrease in spermatogenic function. The basis of this procedure is that the testis receives its arterial blood supply from the spermatic or testicular artery from the aorta, the artery with the vas deferens from the inferior vesical or from the superior vesical, and the cremasteric artery from the inferior epigastric.

Atrophy of the testis with high ligation of the spermatic artery probably occurs rarely. What gave us courage to try the procedure for varicoceles was the fact that no gross atrophy of the testis results from bilateral transperitoneal retroperitoneal lymphadenectomies performed for testicular malignant disease and in each case, the spermatic artery to the normal testis is sacrificed at the level of the aorta. In his classic discussion

of the undescended testis, Wangenstein made mention of the fact that high ligation of the internal spermatic artery and the anterior group of pampiniform plexus of veins may be compatible with a fairly normal spermatogenesis in the tubules. He also stated that a marked diminution in the size of the testis occurs in dogs.

Koyano observed that ligation of the internal spermatic artery and vein in the extraperitoneal region is without considerable effect on the histology of the testis. Burdick and Higginbotham performed complete division of the spermatic cord in 200 cases of inguinal hernia repair and they reported that "many of the testes atrophied but it was surprising how many did not." In clinical observation of our 40 cases, there was no discernible atrophy of the testis.

Spermatogenesis

An attempt was made to ascertain the effects of ligation of the spermatic vessels on the sperm count. These counts have been difficult to obtain for various reasons, but several preoperative and postoperative counts are presented in tables 1 and 2. These counts were all obtained approximately six weeks after the operation and it has been shown elsewhere that any operation on the genitalia can cause a reduction in the sperm count for varying lengths of time and even up to one year.

The last consideration is with the recent reports, especially from Great Britain, of the improvement in the sperm count following surgical treatment for varicoceles. We had one patient on whom a varicocelectomy was performed by ligation of the spermatic artery and vein on the left side strictly for the purpose of improving the sperm count. The patient had previously been treated with thyroid extract and other supportive measures with no improvement in the count. Table 2 shows the numerical improvement in the sperm count and the fact that his wife is now pregnant.

In conclusion, it has been a pleasant revelation to us that the urologist has a procedure for the cure of varicocele. He no longer treats the patient psychiatrically, but surgical correction can be expected by a relatively simple operative procedure.

References are available from the author upon request.

Dr. Levin, 1680 Meridian Avenue, Miami Beach 33139

Table 1
Preoperative and Postoperative Sperm Counts
(Per Cubic Centimeter)

Preoperative	Postoperative
May 27, 1964	June 29, 1964
67,900,000	22,300,000
June 1, 1964	July 16, 1964
31,100,000	12,600,000
June 15, 1964	July 23, 1964
209,500,000	157,700,000
Nov. 13, 1964	Dec. 4, 1964
40,100,000	39,900,000
Jan. 7, 1964	Jan. 28, 1964
19,700,000	14,900,000

Table 2
Sperm Counts of One Patient Operated Upon
Because of a Sterility Problem

Nov. 18, 1963	7,100,000
Varicocelectomy	April 7, 1964
April 20, 1964	23,500,000
July 1, 1964	69,200,000
Sept. 18, 1964	63,300,000
Dec. 1964	wife two months pregnant

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1. Riese, J. A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

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SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylatoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

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Side Effects: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have occasionally been noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by the administration of thiazides.

Contraindications: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

How Supplied: Bottles of 100 and 1000 tablets.

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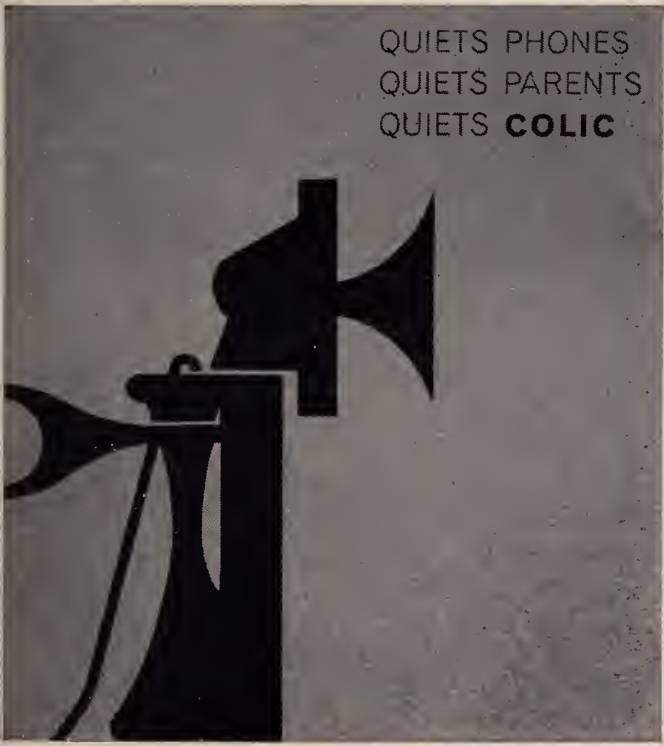
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Medicare And The Doctors

PHILIP R. LEE, M.D.*

The enactment of Public Law 89-97 last July represented the most significant social legislation passed in 30 years.

Certainly few other pieces of legislation have so deeply affected so many Americans. Through Title 18 of the new law, insurance against medical and hospital bills will now be available to all our citizens 65 and over. Before the advent of Medicare, only about half of our older people were covered by private health insurance and often this was inadequate to meet the needs.

Medicare will particularly benefit the elderly poor. The number of impoverished aged in our country totals almost seven million. Every second person living alone or with non-relatives who is classified as poor is aged 65 or older. For these people—the poorest of the aged—Medicare means that they can now receive the same quality of health care that is available to the rest of us. They need no longer fear how the bill will be paid without reliance on charity or placing a heavy financial burden on relatives.

As a result of an intensive public education campaign participated in by government, insurance companies, physicians and thousands of individuals in voluntary organizations, nearly 17 million people have now signed up for supplementary medical insurance benefits. This represents almost nine out of 10 eligible persons aged 65 and over. We believe this kind of response to the voluntary part of Medicare is an overwhelming

vote of confidence from the American people in the medical profession.

As you know, the deadline for enrollment in Part B (medical insurance) of Medicare has been extended by the Congress to May 31. We hope by that time to have reached every eligible older citizen in the country with the facts about supplementary medical insurance benefits.

The provisions of Medicare—both the hospital and medical insurance programs—are probably well known to you by now, but I would like to review them briefly. Suppose an elderly patient, with both Part A and Part B coverage, falls and breaks his hip, requiring hospitalization. He is hospitalized for three weeks and we will assume the bill comes to \$1,000. The patient will pay the first \$40 of hospital cost and the remaining \$960 will be paid by the Social Security Trust Fund. The patient could be covered for 90 days in the hospital; however, after the 61st day, he would have to pay \$10 a day.

Following his period of hospitalization, his physician may determine that the patient needs extended care in a skilled nursing home. If the nursing home expenses for 60 days amount to \$700, we will pay nothing for the first 20 days. The charge to him for the remaining 40 days will be \$5 a day. The balance of \$500 will be paid from the Social Security Trust Fund after January 1, 1967. If it were necessary, he could remain in the extended care facility up to 100 days, paying only \$5 a day beginning on the 21st day.

After the patient returns home, his physician may feel that he requires further care, including the services of a visiting nurse or a physical therapist. If he receives a total of 20 home health

*Assistant Secretary for Health and Scientific Affairs, U.S. Department of Health, Education, and Welfare.

Delivered at the Annual Meeting of the Florida Association of General Surgeons, Hollywood, May 14, 1966. Presented by George A. Silver, M.D., Deputy Assistant Secretary for Health and Scientific Affairs, U.S. Department of Health, Education, and Welfare.

visits at a cost, we will say, of \$300, the full cost will be met through his Medicare insurance. The patient could receive up to 100 home health visits at no cost as long as he is under his physician's care and home-based health services are part of his continuing therapeutic plan.

During the course of the patient's illness, X-rays may be taken in the hospital outpatient department. If the cost of such outpatient diagnostic services amounts to \$75, he will pay the first \$20 and Social Security will pay 80% of the balance, or \$44.

So far we have considered only how Part A of Medicare would help this patient through hospitalization payments, nursing home benefits, and home health services. If he is enrolled in Part B, however, he is eligible for additional benefits. Let us assume that the other-than-hospital services for his broken hip include the following:

Doctor's visits to the hospital, the nursing home, and his own home.

Consultation with an orthopedic specialist.

Rental of a wheel chair and a walker.

Transport in an ambulance from the hospital to the nursing home.

If these expenses total \$300, he would pay the first \$50 and Social Security would pay 80% of the remainder, or \$200. Once he has paid this \$50, he will have to pay only 20% of any additional medical bills which are incurred during the same calendar year.

Under the medical insurance program (Part B) the patient could receive 100 home health visits in addition to those covered under hospital insurance (Part A). He would also receive 80% reimbursement for diagnostic tests and services and for X-ray and radiotherapy not covered under Part A.

Payment of his medical bills can be made in two ways. He can be billed directly. When he pays the bill, his physician receipts and returns it and he sends it to the carrier for reimbursement. The physician is not involved any further.

Alternatively, the physician may accept his patient's "assignment" of his insurance benefit. In that case, he would pay that part of the bill not covered by the insurance; namely, any unpaid part of the \$50 annual deductible plus any other payments for which he is responsible. The in-

surance benefit is then paid directly to the physician by the carrier.

Under either method, the carrier, after the \$50 deductible has been met, will pay 80% of the reasonable charge for the services rendered—to the patient if he has sent in the receipted bill, or directly to his physician.

Needless to say, the first bills to be paid this year under the Medicare program will represent months and months of hard work by literally thousands of people. Mobilization for Medicare has been a momentous undertaking for the Department of Health, Education, and Welfare. It has been a significant educational experience for the Department—an education in cooperation and teamwork.

Seldom if ever before in the 12 year history of HEW have our respective agencies been called upon to work together so closely and continuously. A whole network of new channels for communication and collaboration have been established between the Social Security Administration, the Public Health Service, the Welfare Administration, the Administration on Aging, and the Vocational Rehabilitation Administration. As a result, Secretary Gardner's "new HEW"—built on the increasingly unified purpose and philosophy of its component agencies—is beginning to emerge.

Under the stimulus of Medicare, new bridges of understanding are also being built between the Department and the medical profession. During the past eight months, a steady stream of consultants and advisers from all sectors of the professional health community have come to HEW to give us the benefit of their expert knowledge and experience.

Private physicians have made significant contributions as participants in the various technical work groups, as members of the Health Insurance Benefits Advisory Council, as consultants and through the AMA/HEW liaison group.

The contributions of the private physicians and others from the health care field have been instrumental in developing what we believe to be a workable set of standards and requirements for putting the law into effect. The conditions of participation for hospitals, extended care facilities, home health agencies, and independent laboratories have been announced. These condi-

tions of participation represent the cumulative efforts, over many months, of government and private medicine working with health insurance groups and administrators of health facilities. We have thus successfully begun what will be a continuing process of consultation.

All of the 50 states and the territories have now designated agencies to participate with the federal government in the administration of the Medicare program. Almost exclusively, the state health department has been designated. The principal functions of the state health agency, or other designated state agency, are certification, consultation, and coordination.

Underlying the determination of these important functions are two important principles:

- (1) That the health insurance program should strengthen and support, not supplant or dominate, the direction and growth of existing health services within the states; and
- (2) That the health insurance program should not duplicate unnecessarily such continuing activities as licensing, regional planning, facility survey and construction, standard setting and consultative activities.

The core of the state agency's functions is to certify the providers of service. This activity represents the highest priority for state agencies and it will impose the heaviest workload between now and July 1. It is expected that the great majority of providers will want to participate in the program, and that some of them will need consultation from the state agency in order to meet the conditions of participation.

As you know, utilization review is an essential element in the program. The establishment of a utilization review committee is one of the conditions of participation for a hospital or extended care facility under the hospital insurance part of Medicare. The costs of a utilization review committee are included in the reasonable costs provision of the law, and hospitals and extended care facilities will be reimbursed to the extent that the costs of such activities are related to Medicare beneficiaries.

The purpose of utilization review in the case of hospitals, for example, is to help assure that hospital services will not be used excessively, or

inappropriately, or without consideration of the alternative levels of care that may be paid for by Medicare in its coverage of extended care facilities and home health services. The promise of utilization review is the focus it can give—through discharge planning—on the appropriate type and level of care for the individual patient at each stage of his illness.

The relationship between the physician and the utilization review plan, as we see it, is not one of administrative analysis of professional practices. The rationale is that self-appraisal is the best insurance of quality.

The development of standards and guidelines was worked out by the Social Security Administration in consultation with representatives of the medical profession. The requirements reflect this partnership and cooperative approach.

The utilization review plan must provide for continuing reviews by a utilization review mechanism of the institution's own choice. This may consist of a hospital staff committee including two or more physicians or a group outside the hospital which is similar in composition to the staff committee. However, the utilization review plan must provide for review by a group outside the institution where, because of its small size, it is impractical for the institution to have a properly functioning staff committee for purposes of conducting utilization reviews.

I may say frankly that the states have a very big job of certification and consultation to perform for small institutions and for facilities and programs that we might in all candor call marginal at this point. So you will hear that the state agencies are staffing up to take on the important task assigned to them and you should know that the state agencies must have your support in accomplishing their staffing needs. The job will not even get off the ground if the states do not move rapidly to acquire additional personnel.

The utilization review plan of a hospital should have as its overall objective the maintenance of high quality patient care—achieved through an educational approach involving study of patterns of care and the encouragement of appropriate utilization.

Explicit in this is the inviolability of the physician's right and duty to exercise his medical

judgment. Implicit is the joint hospital-physician responsibility for effective hospital utilization. Because hospitals vary in size and capability in resources, our intent, as was the clear intent of the Congress, is to provide a flexible framework within which hospitals and physicians can develop, in the light of professional considerations, the most appropriate procedures for each individual institution.

In addition to the certification of hospitals and other providers of services, the Medicare legislation also requires the selection of insurance organizations to act as intermediaries and carriers. In the hospital insurance part of the program, intermediaries are selected only after nominations by groups or associations of hospitals, extended care facilities, and home health agencies.

So far, we have selected nine intermediaries for this part of the program. The Blue Cross Association will be the primary intermediary by virtue of being nominated by the American Hospital Association which represents a vast majority of all the nation's short-term, non-federal hospitals. These intermediaries, and some additional ones still to be selected, will be primarily responsible for the payment of hospital benefits and for other relationships with hospitals.

Intermediaries to carry out these same functions with respect to skilled nursing homes and home health agencies have not yet been named. However, nursing home and home health benefits do not begin until January 1, 1967. In the medical insurance part of the program which covers physicians' services, no nominations are made. Instead, the insurance organizations which wish to serve as carriers submit their proposals directly to us. In late November we published the criteria for health insurance organizations desiring to act as carriers for the medical insurance benefits. A total of 49 organizations have now been selected by the department to serve as contractors for the payment of medical bills. Among the 49 are 32 Blue Shield plans, 16 insurance companies and one independent health insurer.

The organizations which have been selected are representative of the different kinds of insurance operations—that is, nonprofit, commercial, home-based, as well as multi-state operations. They also represent a sufficient variety of different-sized service areas. We will thus be able to make

meaningful comparisons, as the Congress intended, of the effectiveness of performance by the different intermediaries and carriers.

In addition, all organizations have been carefully evaluated for their ability to maintain good professional relations with physicians, medical societies, and other professional groups.

One of the most important phases of the intermediaries' job is to determine reasonable charges as the basis for reimbursement. There has been some misunderstanding about this aspect of Medicare which I would like to clarify. The law makes it very clear that medical insurance intermediaries will apply three criteria in determining reasonable charges.

First, they must consider the customary charge generally made by the physician for similar services. Second, they must consider the prevailing charges in the locality for similar services. Third, the intermediary may not determine reasonable charges at a level beyond what would be the basis for making payments to physicians on behalf of its own members or policyholders who receive comparable services under comparable circumstances.

This last criterion is the one which is most often misunderstood. Many people have the mistaken idea that Medicare will adopt the subsidy schedules which have been negotiated between physicians and various Blue Shield plans. These schedules often take into account the income level of the Blue Shield subscriber and may represent a reduced payment agreed to by the physician in some cases. As we interpret the Medicare Law, however, the intermediary will be able to make reimbursement on the basis of its existing programs and fee schedules only to the extent that this enables it to make determinations of reasonable charges in a way that is consistent with all three criteria in the law.

I think it is fair to say that physicians will not find Medicare an unduly inhibiting force in the process of developing a "fair price" level for physicians' services. Although Medicare is a new program, it will be administered within the framework of the relationships which have already been established between insuring organizations and the medical profession. We hope to acquire and to benefit from the methods of negotiation and arbitration which have been used in the past

to settle differences of opinion as to fair reimbursement for a particular medical service in an individual case.

There is one additional requirement for hospitals—and I want to underscore it. In order to be eligible for Medicare funds, as for other federal funds, hospitals must be in full compliance with Title VI of the Civil Rights Act. This is an urgent responsibility for hospitals, for our profession, and for our communities.

We have come to recognize that segregation is an important cause of morbidity and mortality. Negro infants in the United States have double the infant mortality of white infants, Negro mothers four times the maternal mortality of white mothers. In tuberculosis and diabetes, in longevity, Negroes are at a disadvantage compared with their white fellow citizens. It is essential if the people of this country are to receive the highest quality of health services that segregation in the delivery of health services be eliminated.

Last month, the Surgeon General sent a letter to all the hospitals in the United States informing them of the necessity for compliance with Title VI, accompanied by a detailed questionnaire as to their practices in this area. A hundred people are at work in the Public Health Service with a group of consultants to review the compliance status of all hospitals before issuing certification. Without complying with Title VI, no hospital can be eligible for or receive reimbursement from federal funds. We are relying on the cooperation of the hospitals to ensure that failure of compliance will be minimal.

I am sure that physicians who know no barrier of class or race in the performance of their dedicated task of healing will serve as a powerful influence in the community to eliminate segregation and assist hospitals in attaining compliance with Title VI.

Now let us turn to the complementary Title 19 of Public Law 89-97. Title 19 provides a new federal-state program for health care of the needy and the medically indigent under the Social Security Act. The program is based on the experience and the principles of the Kerr-Mills program.

Let me mention first the way in which it supplements the health insurance title—Title 18, or the Medicare program.

Arrangements to pay the deductibles and the voluntary medical insurance premiums for the elderly who cannot afford them are provided through this new federal-state program. Under this Title, states can pay these costs for the aged who are wholly dependent on old-age assistance, and they can also pay the deductibles for persons whose Social Security payments are supplemented with old-age assistance payments.

Title 19 benefits are not limited to the aged, however. This Title establishes a separate and potentially comprehensive program of federal grants to the states for medical assistance to the needy. The grants are administered by the Bureau of Family Services in the Welfare Administration of the Department.

We believe Title 19 to be one of the most significant parts of last year's amendments. When it becomes fully operative, by 1975, virtually all medically needy individuals through the nation should be able to receive comprehensive care. This has not been possible through present federally-aided medical assistance programs. Other age groups among the nation's poor, especially children, have been even less well protected under public assistance programs than have the aged.

The new medical assistance program is designed to close these gaps, and to bring into a continuing pattern of diagnosis, treatment, and restorative care hundreds of thousands of people who lack resources to pay for their own medical care and related health needs.

While Title 18 benefits do not start until July 1, Title 19 became effective on January 1 of this year. The response of the states has been swift and enthusiastic. As of March 10, seven states and Puerto Rico already had medical assistance programs in operation—California, Hawaii, Illinois, Minnesota, North Dakota, Oklahoma, and Pennsylvania.

Health and welfare officials from Puerto Rico and these states, and from Ohio, Washington, New York, Utah, Colorado, and Michigan have met with representatives of the Welfare Administration to discuss their program plans and needs. Altogether, 28 jurisdictions (including Guam, Puerto Rico, and the Virgin Islands) have indicated that they hope to launch the new medical assistance program this year.

The law requires that states which do establish a Title 19 program between January of this

year and July of 1967 must provide some institutional and some non-institutional care for all recipients. This is the same requirement that has applied to the Kerr-Mills program.

After July 1, 1967, however, any state using Title 19 must provide not two, but five minimum services: (1) inpatient hospital services; (2) outpatient hospital services; (3) physicians' services (whether furnished in the office, the patient's home, a hospital, nursing home, or elsewhere); (4) skilled nursing home services for persons over 21; and (5) X-ray and other laboratory services.

You may be interested in other items of health services which the states may include. These are: any type of remedial care recognized under state law which is furnished by licensed practitioners within the scope of their practices as defined by state law; home health care services; private duty nursing services; clinic services; dental services; physical therapy and related services; prescribed drugs; dentures; prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual selects.

Now, who are the people who can receive this range of services? I shall cite them in the priority order spelled out in the law.

First, public assistance recipients. These are the people who receive money payments through the old-age assistance, aid to the blind, aid to the disabled, and aid to families with dependent children programs. Each participating state must provide coverage for at least these groups. The care provided each group must be equal in amount, duration, and scope for all groups involved.

Second, the medically indigent who are not receiving money payments but who could otherwise qualify for public assistance because they meet the state's other eligibility requirements for aid to the blind, disabled, aged, or families with dependent children. Inclusion of this group is optional with the states.

Third, all other medically needy children under age 21. This provision is also optional with the states but will enable those participating to finance a complete range of medical and health services for all needy children.

Like the Title 18 program, those developed by the states under Title 19 will require leadership from the medical profession. The state medical societies will certainly play a key role. In California, for example, they were instrumental in developing the legislation to implement Title 19. That program, in my opinion, is one of the best in the United States.

In the long run, the success of Medicare depends largely on the private physician. Medicare is a tool in his hands. If its full potential is realized, it can be a powerful tool. For Medicare is far more than a reimbursement mechanism. The legislation contains provisions which are designed to support and stimulate the efforts of the health professions to attain quality medical care for all citizens. It also is a major tool for the strengthening of our health care system, based as it is primarily in the private sector.

Payment for services at their full reasonable cost or reasonable charge, for example, will fill much of the financial gap which previously existed when services were provided on a charitable or part-payment basis. Filling the financial gap should help to fill the quality gap and to strengthen the institutions in the process. A firmer financial base should motivate considerable improvement in the capacity of the health professions and health care institutions to furnish more and better services.

Moreover, through the conditions of participation, our nation's health facilities cannot help but be upgraded. Far from being an interference by government, therefore, Medicare represents support from government for the goals which the medical profession has been pursuing for some time.

Even more important, however, is the fact that Medicare represents a mandate from the American people to the medical professional and to the government to provide a means whereby older citizens, the indigent and the medically needy can receive the full benefits of American medicine. I am confident that with statesmanship and responsible leadership on both sides, the people's mandate will be effectively carried out. It is our sincere hope that our partnership toward this end will be worthy both of public pride, and of your professional satisfaction.

The Challenges of 1966

... A Year of Decision

"After Medicare, what?"

Many physicians . . . and others . . . who keep their eyes on the Washington and Tallahassee scenes are asking that question.

The answer is apparent: Those who forced through the Medicare program will try to ram through additional "Great Society" health measures. "Keep hammering away, ad infinitum," is their slogan.

Legislatively speaking, this makes the year 1966 a crucial one. An intense fight to keep Congress from enacting additional dangerous medical-health schemes must be launched.

There is another reason why 1966 will be critical. In November 1966, a new Congress will be elected. Election Day, 1966, will offer an opportunity to change the complexion of the Congress.

If the medical profession desires to play a role in efforts to restore common sense to the Washington scene, it will have to launch a much stronger political action movement than in the past . . . engage in more hard-nose politics . . . in Florida . . . in every state . . . throughout the nation as a whole.

The Florida Medical Political Action Committee stands ready to go to work. It can do a tremendous job, working closely with its national counterpart, the American Medical Political Action Committee, if the physicians of Florida will give it their solid backing and the money with which to provide the tools needed.

FLAMPAC will, of necessity, have to be many, many times bigger and stronger than in 1964 and 1965.

Now is the time for the physicians of Florida to decide whether or not they want to fight . . . or play dead. Now is the time for them to realize that the war hasn't been lost simply because the opposition won a battle by forcing through the Medicare program. In the end, bad as it is, Medicare covers only a tenth of the population. The job ahead is to keep Medicare from being enlarged and expanded to cover more and more segments of the population and try to put a halt to enactment of additional socialistic medical and health programs.

"Make politics a hobby — voting a habit"

JOIN FLAMPAC

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President's Page



United We Stand

The action by the U.S. government through the Department of Justice against the College of American Pathologists contained in a civil antitrust suit is shocking and unwarranted to this writer. The charges in this suit are quite far-fetched and incredible to any sensible person; in fact, they are an insult to the medical profession.

By implication each of the 4,500 physician members of the College of American Pathologists wants to completely monopolize the medical laboratory trade purely in order to increase his own income; and also, each member of this fine organization is accused of arbitrarily keeping the prices of laboratory procedures at artificially high levels solely for personal profit. Furthermore, these fellow physicians are accused of wanting the full 100 per cent of all hospital laboratory income because they desire a working agreement whereby they can practice medicine and bill their patients in the same manner as all other physicians according to our ethical code. The national headquarters of the College of American Pathologists, at the request of the Justice Department, fully and willingly cooperated by allowing a lawyer from the Justice Department to spend several weeks in the headquarters office inspecting all files and records. Then, without any further communication from government, the suit was filed. The papers and news media gave it prominent play.

This should be an omen to all of us of things to come. It might be the kick-off of an organized plan of harassment and attempted intimidation of the medical profession by those in the federal establishment who want to see us completely federalized by a continuing divide and conquer technique—who will be next? There are many in this country who would like nothing better than to destroy the AMA.

I feel that all physicians and all segments of organized medicine should strongly condemn and deplore this action against our fellow physicians. We should support and defend them in every way, and by all means necessary, and at any cost. We must all stand together as physicians and free men in defense of what we think is right.

George S. Palmer

new

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act up and nothing goes right,
I get these throbbing
pains in the back of my head.”**

**a new formulation
that relieves pain
in tension headache
and neuralgia**

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Dialog is well tolerated, even by those sensitive to aspirin. It is nonirritating to the gastrointestinal tract and has no adverse effects on the kidneys.

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Indications: For relief of pain and discomfort of simple headache; neuralgia, myalgia, and musculo-skeletal pain; dysmenorrhea; bursitis; sinusitis; fibrositis. Also indicated to reduce fever and to relieve discomfort due to respiratory infections, influenza, and other febrile conditions.

Contraindication: Not recommended during pregnancy.

Caution: May be habit-forming. Do not use in patients sensitive to barbiturates or in those with moderate to severe hepatic disease.

Side Effects: Nausea, transitory dizziness, rash. Overdosage of allobarbital produces symptoms typical of acute barbiturate excess.

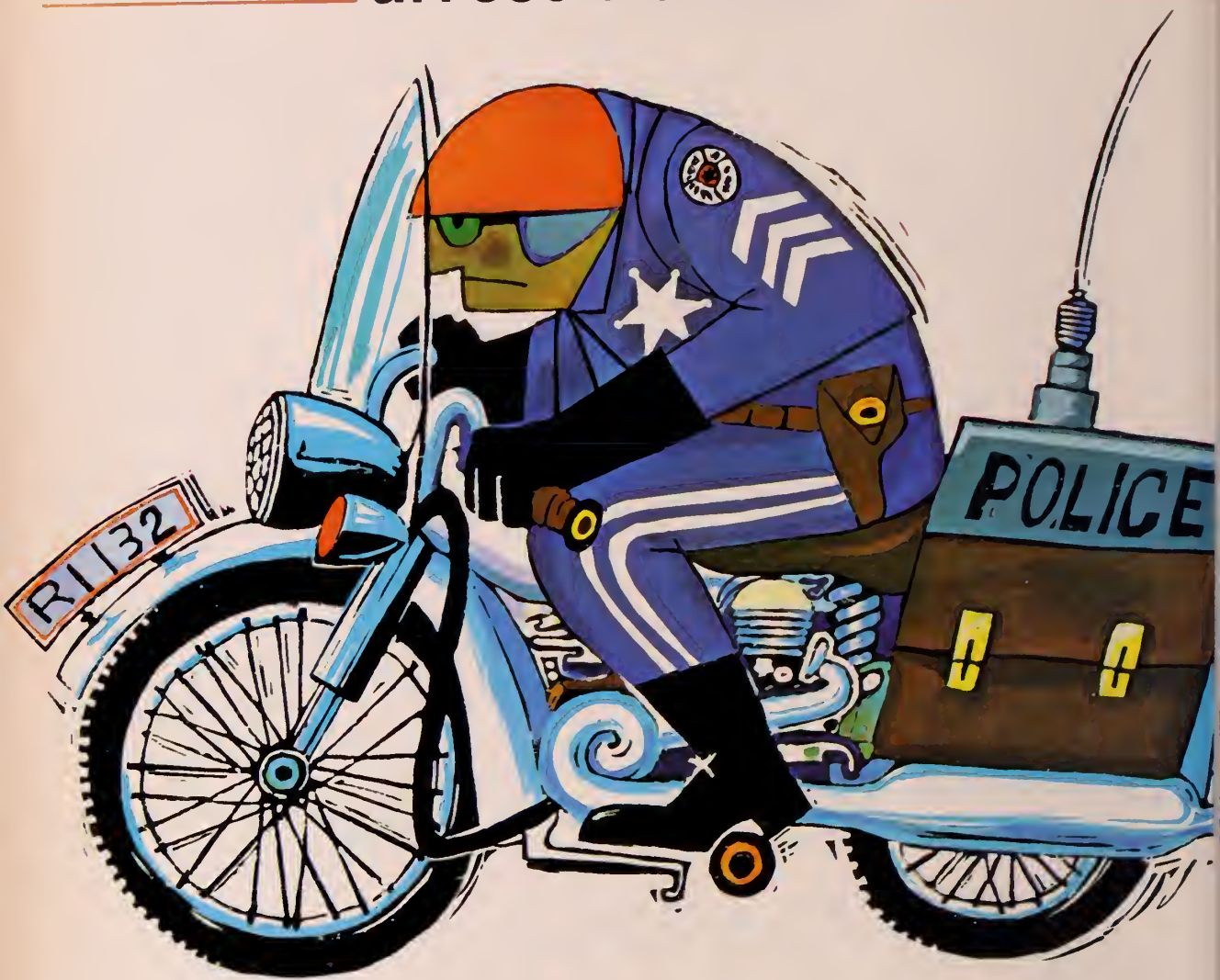
Dosage: *Adults:* 1 or 2 tablets every 4 hours. Not to exceed 8 tablets in 24 hours. *Children 6 to 12:* 1/2 to 1 tablet every 4 hours. Not to exceed 4 tablets in 24 hours.

Supplied: *Tablets* (white, scored), each containing 15 mg allobarbital and 300 mg acetaminophen; units of 3 bottles of 30.

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CIBA Pharmaceutical Company, Summit, N.J.

C I B A

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(Warning: May be habit forming)

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Convenience: Lomotil is supplied as small, easily carried, easily swallowed tablets and as a pleasant, fruit-flavored liquid.

Versatility: The therapeutic efficiency, safety and convenience of Lomotil may be used to advantage alone or as adjunctive therapy in diarrhea associated with:

- Ulcerative colitis
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- Gastroenteritis and colitis

Dosage: For correct therapeutic effect—Rx correct therapeutic dosage. The recommended initial daily dosages, given in divided doses, until diarrhea is controlled, are:

Children: Age	Total Daily Lomotil Dosage	Lomotil Liquid Dosage (Each teaspoonful [4 cc.] contains 2 mg. of diphenoxylate HCl)
3-6 months	3 mg. 	1/2 tsp. 3 times daily
6-12 months	4 mg. 	1/2 tsp. 4 times daily
1-2 years	5 mg. 	1/2 tsp. 5 times daily
2-5 years	6 mg. 	1 tsp. 3 times daily
5-8 years	8 mg. 	1 tsp. 4 times daily
8-12 years	10 mg. 	1 tsp. 5 times daily

Adults: 20 mg. (2 tsp. 5 times daily or 2 tablets 4 times daily) Based on 4 cc. per teaspoonful. Maintenance dosage may be as low as one-fourth the initial daily dose.

Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is a Federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be kept out of reach of children since accidental overdosage may cause severe respiratory depression. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

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Contraindications: Dextro-amphetamine sulfate: in hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.



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693-G

The Urge for Self Destruction

THE HONORABLE MILLARD F. CALDWELL*

Whether in the beginning the Architect of the Universe planned it that way we can only guess, but it does seem true that in each of the human races there is a built-in urge for self destruction—an urge which manifests itself in eras of great progress. The Chinese, the Persians, the Egyptians, the Greeks, the Romans and several nations of more recent vintage all enjoyed periods of great advance in philosophy and science, the arts, literature, religion and government. But strangely, each of those peoples, once having reached a position of great strength, unassailable from without, developed a weakness from within which sapped pride, individual responsibility and independence. And, of course, without citizens in possession of such qualities, those nations fell by the wayside.

If it were given us to know the reason why a people willing to go hungry and scheme and scratch their way out of bondage into freedom, seems always destined to beget a progeny willing to surrender that same freedom without a fight, it is possible we could save for posterity this greatest of all free civilizations we enjoy in America. Without that knowledge, we appear destined for a time of trouble, because, forgetting the sacrifices necessary to gain independence, we have become shockingly selfish—we've swapped the battle cry of "liberty for all" for "what's in it for me now."

It's not enough to shrug it away along with Shakespeare's Puck and his observation of "Lord, what fools these mortals be" because I do not think the Lord intended us to be fools nor to content ourselves with fatalism or resignation. As self-respecting descendants of great forebears logic would suggest that we manifest a willingness to stem the tide of ignominy and re-establish a nation of citizens dedicated to an independent, free civilization. One would think an enlightened

America would scrutinize the pages of history, identify those common weaknesses which beset the no longer great nations of the past and, using that information as a chart, steer a course around the pitfalls.

One weakness which seems to have been common to the great civilizations which have bloomed and faded is that the people evolved a "something for nothing" complex—they demanded handouts, benefits, pensions, free shows and circuses and the political leaders, in order to retain control, taxed the people and pandered to their weakness. Admittedly, the habit of living on a dole is pernicious and highly destructive of the victims—a habit which robbed the people of dead and gone civilizations of the will to work, the desire for independence.

The discouraging thing about the welfare state, and the tax and spend philosophy, is that in all of history no nation, once seduced, has been able to throw it off. It's rather like drug addiction; it goes from bad to worse and finally throttles the instinct for self preservation.

The abuse of unrestrained power by kings, tyrants and courts was responsible for the decline of some of the once great nations. Twice that abuse threatened England, once when King John's tyrannical conduct resulted in the revolt which gave birth to the Magna Charta and, later, when the Star Chamber Courts grossly exceeded their power and so outraged the English people as to cause their abolition.

There's no need to catalog the obvious weaknesses of the civilizations that are no more. The important thing to remember is that, in each instance, had the people retained their strength and will to fight for their rights, they could have been saved.

Curiosity prompts us to ask why we in this country are content to see our leaders launch the ship of state against those same old rocks which

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Read before the Woman's Auxiliary of the Florida Medical Association, Thirty Ninth Annual Meeting, Hollywood, May 13, 1966.

uniformly destroyed other countries? Why do we steer head-on to the shoals of tax and spend for political purposes, the debasement of our currency and the abuse of unrestrained judicial power? I leave to you the supplying of the answer—merely expressing the hope that your conclusion is not that we are so pusillanimously weak we will not stand up for what we know to be right.

As successful professional men and women you have respect for precedent. Let me cite a case in point and let's see if it tells us something worth while about this country of ours.

The Roman Republic, the foremost power of its day, had reached its zenith. Its leadership had attained unbounded wealth and unstinted power. The rulers were intolerant of restraint, indifferent to the demands of the middle class and contemptuous of the Constitution designed to curb their ambitions. The time was some 70 years before the birth of Christ.

Young Marcus Tullius Cicero, then a student of law under old Scaevola, the eminent lawyer of his day, was just about to suffer his first great disillusionment with grasping government. Rome, by force of arms, guile and trickery, dominated the world. Its citizens had grown slick and fat, careless of their rights, and had fallen prey to ruthless politicians who craved more and ever more power and riches.

Cicero's first client was a substantial man of business—a man of integrity who trusted his government and his fellow man. But he was a rich man and, because powerful men of government coveted his wealth, he was the victim of bureaucratic chicanery. Young Cicero submitted documentary proof of his client's defense to the Judges, confident that justice would prevail.

Many of us who have watched with amazement the Supreme Court of the United States repudiate both precedent and the Constitution in its creation of new political policy for the guidance of this country can see a parallel in what happened next.

The case was not going well and Cicero consulted with his great friend and mentor, Scaevola, telling him what course he had followed and asked why he had failed. Scaevola was disgusted. He slammed the table and, leaning toward Cicero, shouted, "Imbecile! Of what use are records presented to tribunes, consuls or senators if the

government is determined to rob and destroy a man who had displeased them, or who possessed what they want? Have I truly wasted all these years on such an idiot?"

If you deplore the spending of multiple billions on Nasser, Tito and the tribes of Africa, listen to this for precedent:

Cicero, before the august Senate, pleaded his client's defense against confiscation, saying:

We are taxed in our bread and our wine, in our incomes and our investments, on our land and on our property, not only for base creatures who do not deserve the name of man, but for foreign nations, for complacent nations who will bow to us and accept our largesse and promise us to assist in the keeping of the peace—these mendicant nations who will destroy us when we show a moment of weakness or our treasury is bare, and surely it is becoming bare. We are taxed to maintain legions on their soil, in the name of law and order. We keep our allies in precarious balance only with our gold. Is the heart-blood of our nation worth these? Shall one Italian be sacrificed for Britain, for Gaul, for Egypt, for India, even for Greece, and a score of other nations? Were they bound to us with ties of love, they would not ask our gold. They would ask only our laws. They hate and despise us. And who shall say we are worthy of more?

What then occurred may throw some light on our indifference to government preoccupation with our personal affairs and our unwillingness to "rock the boat."

Cicero did not save his client, but he did live to argue the cause of honest government and to talk with Sulla, the Consul, about integrity and fair dealing. Sulla had little faith in the people. He believed them too deeply interested in their own welfare to concern themselves, too timid to stand up for their rights. He told Cicero the middle class, the lawyers, the physicians, the bankers and the merchants would make no sacrifices. He said none of the lawyers will challenge the lawmakers and cry to them, "This is unconstitutional, an affront to a free people, and it must not pass!" He asked:

Will one of these (friends of yours) lift his eyes from his ledgers long enough to scan the Twelve Tables of Roman Law, and then expose those who violate them and help to remove them from power, even if it costs their lives? These fat men. Will six (lawyers) in this city, disregarding personal safety, rise up from their offices and stand in the Forum, and tell the people the inevitable fate of Rome unless they return to virtue and thrift and drive from the Senate the evil men who have corrupted them.

Rome continued to decay. The ambitious were fattening upon its bones. The liberties of the people were lifted one by one in the name of

emergencies or trade in on benefits. Catiline, brilliant, uninhibited and evil, was pressing his suit for leadership.

As you watch the progress of government-sponsored demonstrations, the loving care with which the rioters are treated and the wholesale reversal of criminal convictions, listen to what Cicero, in his Second Oration before the Senate, had to say:

Too long have we said to ourselves "Intolerance of another's politics is barbarious and not to be countenanced in a civilized country." Are we not free? I tell you that freedom does not mean the freedom to exploit law in order to destroy it! It is not freedom which permits the Trojan Horse to be wheeled within the gates. . . . He who is not for Rome and Roman Law and Roman liberty is against Rome. He who espouses tyranny and oppression and the old dead despotisms is against Rome. He who plots against established authority and incited the populace to violence is against Rome. We cannot be for lawful ordinances and for an alien conspiracy at one and the same moment.

As you read the strained constructions placed upon the general welfare and interstate commerce clauses of the Constitution and marvel at the results reached by the Supreme Court, listen to this precedent:

Cicero said: "Though liberty is established by law, we must be vigilant, for liberty to enslave us is always present under that very liberty. Our Constitution speaks of the 'general welfare of the people.' Under that phrase all sorts of excesses can be employed by lusting tyrants to make us bondsmen."

As the years went by Cicero continued his struggle; he became Consul and, for a time, stopped waste and thievery. But the people again grew careless, weary of well-doing, and the avaricious and the corrupt politicians moved in and sought to banish Cicero. Once again he appeared before the Senate, but this time to plead his own cause.

Crassus, Caesar and Pompey were present. He turned and looked at them, but their faces were shut against him. His smile was sad as he said to them, "You have succeeded against me. Be it as you will. I will depart. . . ."

Then bearing in mind that our own government is pretty well riddled with subversives in high places, listen to Cicero as he defended his cause:

For this day's work, lords, you have encouraged treason and opened the prison doors to free the traitors.

A nation can survive its fools, and even the ambitious. But it cannot survive treason from within. An enemy at the gates is less formidable, for he is known and he carries his banners openly against the city. But the traitor moves among those within the gates freely, his sly whispers rustling through all the alleys, heard in the very halls of government itself. For the traitor appears no traitor; he speaks in the accents familiar to his victims, and he wears their face and their garments, and he appeals to the baseness that lies deep in the hearts of all men. He rots the soul of a nation; he works secretly and unknown in the night to undermine the pillars of a city; he infects the body politic so that it can no longer resist. A murderer is less to be feared. The traitor is the carrier of the plague.

Cicero was exiled from Rome but not from his conscience. He continued to plead the cause of honest government. But the people he pleaded for were not concerned.

Cicero's friends of 2,000 years ago had about the same attitude our friends have in this Great Society era of 1966. The business and professional men, those who, had they lived in 1966, would have been members of the Chamber of Commerce, Rotary, Kiwanis and Exchange, told him: "We do not meddle in politics. Rome is prosperous and at peace. We have our villas in Caprae, our racing vessels, our houses, our servants, our pretty mistresses, and our comfort and treasures. We implore you, Cicero, do not disturb us with your lamentations of disaster. Rome is on the march to the mighty society for all Romans."

Cicero was in despair. He began to write his book *De Legibus*, but Atticus, his publisher, asked, "But who will read it? Romans care nothing for law any longer, their bellies are too full."

And then, Brutus, the long time sycophant of the ambitious Caesar, came to his senses and went to Cicero with his plea that something be done to save the nation. He confessed his error, he said he had believed in Caesar, he had believed he would restore the Republic, but he had betrayed his trust.

Cicero's bitter reply was: "Do not blame Caesar, blame the people of Rome who have so enthusiastically acclaimed and adored him and rejoiced in their loss of freedom and danced in his path and gave him triumphal processions. Blame the people who hail him when he speaks in the Forum of the 'new, wonderful good society' which shall now be Rome's. Julius was always an ambitious villain, but he is only one man."

I am not sure just where this country is going nor what life in America will be like five, ten or fifty years from now. But it's clear that the old ideas of supply and demand and the old concepts of local self government and individual responsibility have been discarded. And it's equally clear that the civic organizations generally are shirking the duty to safeguard the principles of free government.

It strains complacency to contemplate the changes which have occurred in the last thirty years. Our manner of government and our way of life are, for the United States, new and novel, with little in common with what has gone before. Our forefathers would be astounded by the insidious encroachments of centralized government in our everyday life.

Government is in the business of housing the people, in prescribing the hours we can work, with whom we must work, the salaries we are paid and the tax to be withheld from that salary, the schools our children can go to and with whom they must sit and play. It is meddling with your health, your general welfare, your old age and your retirement, your security after retirement, your savings and the banks in which you place your savings, the conduct of your city, its police department and its department of health; the conduct of the affairs of your state, its law enforcement, its elections, the composition of its legislature and every other facet of your life, private and public.

But the people of this country may like all this—to say the least, they have asked for it. They have elected the public officials who brought it about and they sit around with their tin cups waiting for more. If that's what a majority of the people of this nation truly want, we must accept it—the majority has the right to change our form of government if it wishes.

But one unfortunate aspect is that, once the die is finally cast, it will be too late to change our minds; it's altogether unlikely we could then ever re-establish the kind of government, the kind of independence and individuality our forefathers conceived and anticipated for posterity. We will have come too far and given up too much.

For that reason it is important that we give some thought to what is happening and reach

some conclusions about what we'd like our future to be. We must count the cost of all the politically inspired humanitarian claptrap and be sure we're willing to pay the price in freedom, liberty and independence.

The first thing to decide is whether we want to live in a constitutional Republic or under a centralized socialism. Theoretically, I suppose the vast majority would say they prefer constitutional government, but as a matter of truth, that same majority is unwilling to jeopardize current prosperity linked to socialistic and inflationary practices. Indeed, it may be we are irrevocably committed—too many of us have sold the future for the hope of free medical care, free college education, social equality and security against poverty.

In good conscience, we cannot say the federal encroachments upon our rights and the rights of the states have come with any surprise. We have been warned and warned again. Two thousand years ago Cicero told us what to expect. When our ancestors were considering the adoption of the Federal Constitution for the new Republic, Patrick Henry, distrusting a central government, with true and unerring foresight told the people to "be extremely cautious, watchful, jealous of your liberty. Instead of securing your rights, you may lose them forever." He said, "There will be no checks, no real balances in this government." Looking ahead to 1966, he said, "This government will . . . destroy the state governments and swallow the liberties of the people."

George Mason was fearful of centralization and thought there was a very real danger of losing all the Revolution had gained. He said that a consolidated government "is totally subversive of every principle which has hitherto governed us."

William Grayson was suspicious of the proposed Supreme Court. He said, "This court has more power than any court under heaven . . ." George Mason agreed and said the creation of the court would result in the destruction of state governments because, in the absence of restraint, the court "will be the judges of how far their law will operate."

Benjamin Franklin, after the Constitution was adopted, anticipating a people negligent in safe-

guarding their rights, said he thought our government would be well administered for a few years but that it "can only end in despotism."

At the conclusion of his two terms as President and in the light of his experience, George Washington thought the people of the future should be warned of the dangers inherent in an unrestrained Supreme Court. He said: "If . . . the distribution . . . of the constitutional powers be in any particular wrong, let it be corrected by an amendment in the way which the Constitution designates. But let there be no change by usurpation; for though this, in one instance, may be the instrument of good, it is the customary weapon by which free governments are destroyed."

Thomas Jefferson foresaw the evil of judicial encroachment when, in effect, he said the Court, under its philosophy, made the Constitution a mere thing of wax to be twisted into any form it pleased; that to consider the Judges the ultimate arbiter of the Constitution would place us under the despotism of an oligarchy.

Some years later Lord Macauley, the English historian, after a careful study of our government in general and our Constitution in particular, warned the American people:

Your Constitution is all sail and no anchor. Either Caesar or Napoleon will seize the reins of government with a strong hand, or your Republic will be as fearfully plundered and laid waste by the barbarians in the twentieth century, as the Roman Empire was in the fifth—with this difference, that the Huns and Vandals who ravaged the Roman Empire came from without, and your Huns and Vandals will have been engendered within your own country by your own institutions.

It is reasonable to assume he thought the Supreme Court was one of the institutions which would destroy us from within.

Abraham Lincoln thought it necessary to tell the people: "If the policy of the government upon vital questions affecting the whole people is to be irrevocably fixed by the decisions of the Supreme Court the people will have ceased to be their own rulers, having to that extent practically resigned their government into the hands of that eminent tribunal."

Robert Moses had this to say the other day:

We are living in a second American Revolution, as critical as the first one which established our nation . . . the Supreme Court now legislates and executes. . . . It now by-passes the state courts and delegates to lower federal courts authority to tell the states what to do and how to do it . . . the states are reduced to peonage . . .

until we change our Constitution, any five judges out of nine—distinguished men no doubt but political accidents not chosen by the people—are ruling the country and determining its future.

No, we cannot have been surprised by what has happened because, from our earliest days, we have been on notice it would happen. We, very simply, have refused to heed the warnings.

The whole trouble is that, in our civic stupor, we have forgotten that major policies, whether the gift of our substance to the communists or the regimentation of industry, agriculture, business and the professions, require either the approval or acquiescence of the citizens of this country. What has been done, both that which has contributed to our stability and that which has endangered our future, has been with our consent.

It is no longer of first importance whether we collectivize the professions or bankrupt the nation in abolishing poverty or in supporting our enemies abroad. The vital question, the question in the face of which all others fade to insignificance, is whether we save the Constitution of the United States and the Republican form of government established by it.

And, of course, saving the Constitution involved getting the Supreme Court out of the policy-making field and back on the Bench of a Court of law.

We must admit that many people, many splinter groups, approve one or the other of the encroachments by the Supreme Court upon the rights of the majority. The Negroes are happy in the belief that the Brown decision established superior rights for them over the majority; the criminals are happy with the Mallory and Escobedo decisions because of the great advantage gained over the law enforcement officers and society in general; the communists thoroughly approve the Schware, Konigsberg and the Slochower cases which insure their right to infiltrate the legal profession and the schools. The labor unions like the decisions which gave to them enormous advantages. The urban politicians like the reapportionment decisions which insure their control of the state houses and the Congress.

By coddling particular self-interest groups, one after the other, the "rule by man" forces have built a strong following—a following which is active, vocal and organized—composed of the

neuter moderates, the ADAers, most of labor, practically all of the minorities, many ministers and many of the business and professional world. But I do not believe the tin cup crowd constitutes a majority of the people of this country.

The simple majority, and I emphasize the word simple, composed of decent, ordinary businessmen, doctors, farmers, mechanics, preachers, and just people, does not realize how it has been duped. The honest fellow has always been an easy mark—the easiest to rob.

The simple majority is slow to anger, not given to sit-downs and sit-ins, to placards and to violence and to hate. But neither is that majority watchful of its own rights and the freedoms it inherited from brave ancestors.

But there's a great difference in the composition of nationalities. Three or four hundred years ago the English, pushed to the wall by the power-spawned rule of the Star Chamber Courts, pushed back and recaptured their rights. The Russian people, in sheeplike docility, have submitted. The melting pot of America seems content and complacent. Its sycophantic Congress, reflecting public acquiescence, is groveling at the feet of the President. Its Democratic party has been captured and its Republican party is without policy or guidance. We appear to be drunk on benefits and slogans, rushing lightheartedly along to self destruction.

But perhaps all this is in keeping with natural law. The children of Hamlin followed the Pied Piper to ruin, the people of Germany and Italy followed Hitler and Mussolini, the ratlike lemming of Norway rush to the sea to drown, the sucker-like grunions of the Pacific rush from the sea to flop on the beach and die. The Roman republic was destroyed when the urban leaders pampered its populace with free handouts and a promise of a better day. Perhaps Benjamin Franklin knew what he was talking about when he told the young nation, after it had adopted its Constitution, in substance, that it had gained a free and independent nation but did not have the common sense to keep it.



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Reference: 1. Roberts, C. E., Jr.; Perry, D. M.; Kubaric, H. A., and Kirby, W. M., M. A. M. A. Arch. Int. Med. 107:204 [Feb.] 1961.

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Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should be used with greater care in the elderly and should not be given when the patient is senile or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

Warning

If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time.

Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Use with caution in the first trimester of pregnancy.

Precautions

Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made to guard against blood dyscrasias.

Adverse Reactions

The most common adverse reactions are nausea, edema and drug rash. Moderately lowered red cell count may sometimes occur due to hemodilution. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vertigo or languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be

attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects.

Confusional states, hyperglycemia, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported. Some patients have hepatitis, jaundice and several cases of anuria and hematuria. With long-term use reversible thyroid hyperplasia may occur infrequently.

Dosage

The initial daily dosage in adults is 300-600 mg. daily in divided doses. In most instances, 400 mg. daily is sufficient. When improvement occurs, dosage should be decreased to the minimum effective level; this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

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Phenylketonuria Testing in the Newborn

A bill which would have required the testing of all newborn infants for the syndrome known as phenylketonuria (PKU) was considered by the last session of the state legislature. A substitute proposal was passed, however, requiring the reporting of all positive cases, and the promotion of testing on a voluntary basis by the Florida State Board of Health. Thus, organized medicine in Florida was given the opportunity to prove that an important objective can be achieved without legislative intervention.

Recognizing that some hospitals do not keep mothers and infants long enough (more than 48 hours) to permit an adequate period of protein feeding while in the facility, which is necessary for the possible detection of phenylketonuria, the Special Advisory Committee to the State Board of Health composed of physicians in the various specialties and in public health plus representatives of the Florida Hospital Association has proposed and agreed upon a combination program.

1. When the infant is discharged from the hospital before sufficient time has elapsed to permit adequate protein feeding, the parents should be notified in writing that a test has not been performed and that the infant should be tested by their physician within 10 days.

2. All physicians caring for infants immediately after birth and for the subsequent several days should ascertain whether a test has been done. When the test has not been performed, it should be ordered prior to discharge from the

hospital—after the infant has been on protein feedings for 24 to 36 hours.

3. Hospitals keeping newborns for a period of 72 hours should arrange for the Guthrie or a similar reliable test to be performed on each child prior to discharge. The test should be delayed until the baby has been on protein feedings for 24 to 36 hours.

4. Each county health department should arrange for the Guthrie or other reliable test for each infant presented to child health conferences as early in life as possible when it is questionable that a test has been performed. This plan would assure testing of infants delivered at home and those of indigent families who did not receive the test in the hospital.

5. Laboratory evaluations of the Guthrie or similar reliable test may be processed by physicians and hospitals through the facilities currently utilized. In addition, the State Board of Health Central Laboratory in Jacksonville and the Regional Laboratory in Miami will accept, perform and report on tests. The laboratory in Jacksonville will provide materials for obtaining the Guthrie test specimen to physicians and hospitals, upon request, who wish to use its facilities for screening.

6. All suspicious or positive cases should be reported to the State Board of Health on a prescribed report form, which is available upon request from the Bureau of Maternal and Child Health.

7. The indigent family having a child with phenylketonuria may obtain the necessary dietary supplement without charge from the State Board of Health when the physician caring for the child provides a statement that the family is medically indigent and cannot afford the preparation.

8. A succinct fact sheet is being planned for enclosing with all birth certificates issued by the State Board of Health. It will inform the parents of the serious nature of untreated phenylketonuria and urge that a test be made on the infant in the event one has not been done.

The Special Advisory Committee is of the opinion that the urine test is not adequate evidence of absence of phenylketonuria. The negative urine test signifies nothing; a positive reaction indicates that additional tests should be made to determine the true status. A positive reaction from the Guthrie test of over 4 mg. of incomplete metabolic products of phenylalanine/100 ml. of blood is a presumptive indication and requires further evaluation including a serum phenylalanine determination.

With adequate cooperation by physicians, hospitals and county health departments, sufficient emphasis can be given to phenylketonuria which will assure virtually 100% testing on a voluntary basis. Apart from any possible legal action by parents which might arise when testing is neglected, physicians are professionally and morally obligated to provide the assurance to all parents that their child has been accurately tested and is not in danger of developing a progressively serious mental condition.

DAVID L. CRANE, M.D., DIRECTOR*
BUREAU OF MATERNAL AND CHILD HEALTH
FLORIDA STATE BOARD OF HEALTH
JACKSONVILLE

LEO M. WACHTEL, M.D., CHAIRMAN
SPECIAL ADVISORY COMMITTEE
FOR PKU TESTING
JACKSONVILLE

*Presently Director, Sarasota County Health Department.

Public Law 89-239

In March 1964, the President of the United States appointed a Commission on Heart, Cancer and Stroke to "recommend steps to reduce the incidence of these diseases through new knowledge and more complete utilization of the medical knowledge we already have." No one can object to such a charge. As a result of the study by the Commission, with Dr. Michael E. De Bakey as chairman, a bill was introduced which would have established complexes, associated with medical schools, to diagnose and treat patients with heart disease, cancer, stroke and other major diseases. This program would have greatly interfered with private practice and would have placed a tremendous and undesirable burden on medical schools.

Through the efforts of the American Medical Association, the American Academy of General Practice, several state medical societies and others, the bill was amended in such a way that it now applies to research and education limited to heart disease, cancer, stroke and allied diseases and affords an opportunity for local or community hospitals and private practitioners to participate in well planned programs of continuing education.

As written, the bill prohibits use of funds to pay for care of patients except when such care is incident to research, training or demonstration activities. All patients must be referred by a physician. Herein lies means for preserving private practice. New construction is also prohibited under this bill.

Advisory committees are composed in such a way that there is *local* control of programs. Local committees must have, as members, practicing physicians and members of the public, as well as medical school representatives. Local committees must approve programs before they will be considered by the National Advisory Council, which also is required to have practicing physicians as members.

The Florida Medical Association has formed an advisory council with broad representation which includes several physicians in private practice as well as representatives of teaching centers, hospital administrators, public health authorities, volunteer health agencies, and lay public. Under the guidance of this council regional or local planning committees will be formed to plan programs which must, in order to be approved, include participation of hospitals engaged in the

treatment of patients. The congressional committee which studied this bill calls for the full participation of practicing physicians so as to fill the need for continuing education. This aspect is also approved by a recent statement of policy by the Regents and Governors of the American College of Surgeons.

It would appear from my study of the bill and report of hearings that this program is one which could benefit all of us and our patients and will give us, the private practitioners, a great deal to say about how the program will progress. I urge each member of the Florida Medical Association to study the bill with an open mind, forgetting for the moment that this is another program sponsored by the federal government. This one is for us and should benefit our patients.

WILLIAM H. PROCTOR, M.D.
WEST PALM BEACH

No Saskatchewan in Florida

In Saskatchewan on July 1, 1962, physicians went on strike in protest against a Medicare Plan.

In Florida on July 1, 1966, physicians did not go on strike against a Medicare Plan, but rather will continue to practice medicine to the best of their ability.

Why does one group of physicians go on strike while another group does not? Maybe the reason is in part that in 1966 in Florida, and in the United States in general, individual physicians are secure personally as well as professionally and hence are not as apt to take imprudent action.

Individual physicians frequently are more secure and less readily threatened by socioeconomic change than is indicated by the agitated political behavior of many medical organizations.

Organized medicine often seems to follow rather than lead individual physicians (as well as non-physicians) politically. Medical organizations have at times decried the apathy of individual members concerning imminent socioeconomic changes when in reality these individual physicians may have been just more secure than their medical organizations and therefore not as threatened concerning conditions.

The political anxiety level of organized medicine has been extremely high. Members of medical organizations have been asked to use their offices and homes to influence friends and patients toward the medically prescribed political position on "social ills." Politics has been among the first orders of the day for organized medicine for too

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long. It is one thing to drink and be refreshed at the political well; it is another thing to drown.

One recalls in the recent past such medical organizational urgings as "write your congressman today or all is lost." We were even told how and what to write. The political panic button was pressed so often by some medical organizations that many individual physicians just ran out of panic.

Our political endorsement of candidates who promised to preserve the status quo or obstruct the inevitable tide of socioeconomic change was as obvious as it was ineffective.

Our patients, knowing that we were doctors of medicine and not doctors of any political science, usually voted for the candidate of their own choice, and medically "approved" candidates usually met defeat at the very hands of our own patients on the voting levers.

In my opinion organized medicine would benefit from a pan-politicsectomy. It has been our privilege as physicians to be entrusted with the care of the sick. Whereas our services have been largely unsupervised and our fees unregulated, we are now seeing changes toward supervision and regulation of our services and fees which in my opinion are inevitable.

On the premise that medical organizations may have higher "anxiety levels" than their individual members, I predict that medical organizations will continue to protest actively against Medicare as a plot, long after the average physician has accepted Medicare as a plan.

In summary:

(1) The average physician in Florida and in the United States has come through personally as well as professionally in his dedication to the continuing good care of patients of all ages.

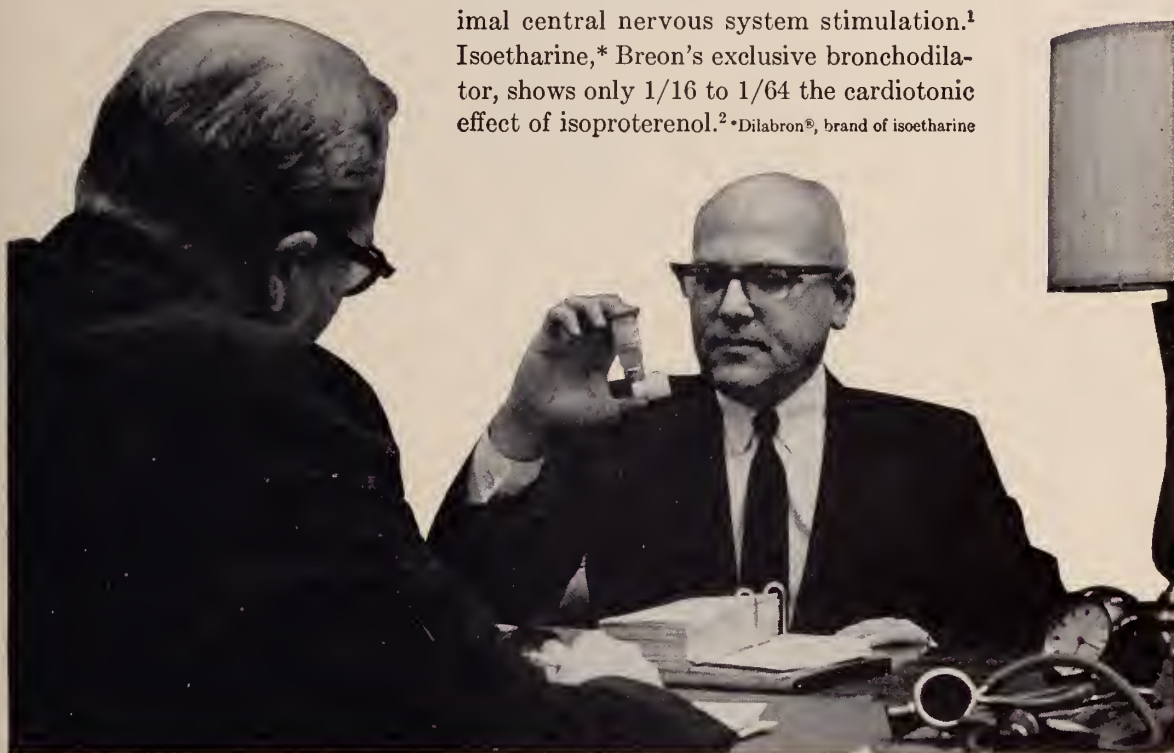
(2) Medical organizations in my opinion have tended to reflect more the fever of some of their members than the cool of others. This organizational anxiety state may result in unfortunate political pronouncements and behavior which may be a source of embarrassment or even detriment to the physician in the doctor-patient relationship.

(3) I must congratulate my fellow physicians in Florida and elsewhere in the United States upon their primary dedication to their patients' welfare which has allowed them to take the inevitable socioeconomic change in stride.

JOHN J. McANDREW, M.D.
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References: 1. Spielman, A. D.: *Curr. Therap. Res.* 3:235 (June) 1961. 2. Herschfus, J. A.; Bresnick, E.; Levinson, L. J. and Segal, M. S.: *Ann. Allergy* 9:769 (Nov.-Dec.) 1951.

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McNeill, A. J.: Clin. Med. 8:518 (Mar.) 1961.

"Mediatrix (steroid-nutritional compound) capsules, one a day, seem to give definite help to debilitated patients."

Arnold, E. T., Jr.: Geriatrics 12:612 (Oct.) 1957.

"Nutritional and hormone bolstering of function in the aged may have a useful place in geriatrics."

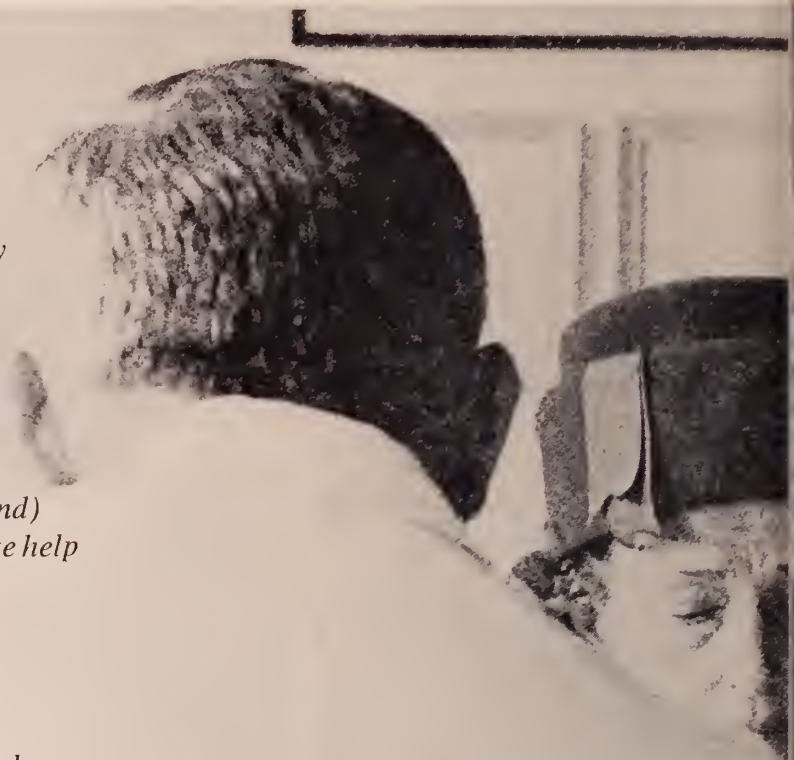
Morgan, A. F.: Gerontologist 2:77 (June) 1962.

"In diets which for any reason are restricted in calories, enough of these substances (B vitamins) may not be supplied... The use of B and C vitamin supplements may then be justified and indeed may be necessary."

Morgan, A. F.: Gerontologist 2:77 (June) 1962.

"Intensive nutritional therapy is necessary, especially in elderly people, to correct dietary deficiencies created by large losses of protein, vitamins and other nutrients."

Riccitelli, M. L.: J. Am. Geriatrics Soc. 12:489 (May) 1964.



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Designed for the "metabolically spent"

Nutritional reinforcement for those who can't
—or won't—eat properly...balanced amounts of
estrogen and androgen to counteract declining
gonadal hormone secretion and its sequelae of
premature degenerative changes...mild
antidepressant for a gentle "mood" uplift...

The estrogen component in MEDIATRIC is
PREMARIN® (conjugated estrogens—equine),
the natural estrogen most widely prescribed for its
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MEDIATRIC also provides *nutritional reinforcement—blood-building factors and vitamin supplementation*. It contributes a gentle "mood" uplift
through methamphetamine HCl.

Three different dosage forms—Liquid, Tablets, and
Capsules—offer convenience and variety.

MEDIATRIC Liquid

Each 15 cc. (3 teaspoonfuls) contains:

Conjugated estrogens—equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
Thiamine HCl	5.0 mg.
Cyanocobalamin	1.5 mcg.
Methamphetamine HCl	1.0 mg.

Contains 15% alcohol

MEDIATRIC Tablets and Capsules

Each MEDIATRIC Tablet or Capsule contains:

Conjugated estrogens—equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
Ascorbic acid	100.0 mg.
Cyanocobalamin	2.5 mcg.
Intrinsic factor concentrate	8.0 mg.
Thiamine mononitrate	10.0 mg.
Riboflavin	5.0 mg.
Niacinamide	50.0 mg.
Pyridoxine HCl	3.0 mg.
Calc. pantothenate	20.0 mg.
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Methamphetamine HCl	1.0 mg.

Orally active, water-soluble conjugated estrogens derived from
pregnant mares' urine and standardized in terms of the weight
of active, water-soluble estrogen content.

MEDIATRIC helps keep the older patient alert and active;
helps relieve general malaise, easy fatigability, vague pains in
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usually associated with declining gonadal hormone secretion.

CONTRAINDICATION: Carcinoma of the prostate, due to methyl-
testosterone component.

WARNING: Some patients with pernicious anemia may not
respond to treatment with the Tablets or Capsules, nor is
cessation of response predictable. Periodic examinations and
laboratory studies of pernicious anemia patients are essential
and recommended.

SIDE EFFECTS: In addition to withdrawal bleeding, breast ten-
derness or hirsutism may occur.

SUGGESTED DOSAGES: *Male and female*: 3 teaspoonfuls of
Liquid, 1 Tablet, or 1 Capsule, daily or as required.

In the female: To avoid continuous stimulation of breast and
uterus, cyclic therapy is recommended (3 week regimen with
1 week rest period—Withdrawal bleeding may occur during
this 1 week rest period).

In the male: A careful check should be made on the status
of the prostate gland when therapy is given for protracted
intervals.

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fluidounces and 1 gallon. No. 752 — MEDIATRIC Tablets,
in bottles of 100 and 1,000. No. 252 — MEDIATRIC Cap-
sules, in bottles of 30, 100, and 1,000.



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steroid-nutritional compound

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MOLECULAR REMODELING—

laboratory exercise or clinical necessity?

More than twenty-five years have passed since the discovery of the diuretic activity of sulfanilamide started pharmacologists on a succession of molecular remodeling to find the ideal diuretic.

Diuresis—a sought-after clinical effect from an unwanted side effect

It started in 1937 when a clinician reported that the administration of a sulfonamide was sometimes accompanied by an unexplainable side effect—metabolic acidosis.¹ Three years later the side effect was explained. The sulfonamide radical of sulfanilamide inhibited carbonic anhydrase,² the enzyme responsible for converting carbon dioxide and water to hydrogen ions and bicarbonate ions.

Later, other investigators showed by dog experiments that metabolic acidosis probably resulted when the inhibition of carbonic anhydrase upset the exchange of hydrogen and sodium ions, causing increased excretion of sodium as the bicarbonate.³

It was twelve long years after the first report of the unexplainable side effect (metabolic acidosis) that it was finally shown that large doses of sulfanilamide administered to edematous patients were indeed capable of promoting diuresis.⁴ However, the possibility of toxic effects from its prolonged use and its relatively weak diuretic action made it impractical for clinical use as a diuretic.⁵

Because the inhibition of carbonic anhydrase seemed to be the key to effective diuresis, investigators began to look for more potent enzyme inhibitors—in the hopes that they would be more effective diuretics.

The most important of these early compounds, acetazolamide, enjoyed several years of fairly wide clinical use.

Its carbonic anhydrase inhibitory activity was several hundred times greater than that of sulfanilamide.⁶ The increase in inhibitory activity, however, increased not only the excretion of sodium and bicarbonate ions, but also the excretion of potassium.⁷ And, like its predecessor, acetazolamide precipitated mild acidosis. Its prolonged use could result in hypokalemic acidosis.⁷

The 'thiazides'—an answer to the metabolic acidosis caused by carbonic anhydrase inhibition

Despite the fact that the sulfonamide

group appeared to be responsible for carbonic anhydrase inhibition which in turn appeared to be responsible for diuresis, investigators began to synthesize compounds with structural alterations to the sulfonamide group.

The first major breakthrough came with the synthesis of chlorothiazide. Altering the sulfonamide group did indeed alter the ability of chlorothiazide to inhibit carbonic anhydrase—it was only 1/10th as potent as acetazolamide in inhibiting the enzyme.⁸ Despite the drop in inhibitory potency, however, chlorothiazide proved to be an effective diuretic—an observation that led to the conclusion that its diuretic action was due to some mechanism other than its action on carbonic anhydrase.^{9,10}

For effective diuresis, chlorothiazide was administered in daily dosages ranging from 250 to 2000 mg.¹¹ It increased the excretion of sodium and chloride; and, to a lesser extent, potassium and bicarbonate.¹¹ The excretion of potassium appeared to be maximal at higher dose levels at which, theoretically, the carbonic anhydrase inhibitory effect is more active.¹¹ Its prolonged use, therefore, could sometimes result in metabolic hypokalemic, hypochloremic alkalosis.⁷

Naturetin—effective diuresis with more favorable electrolyte balance

Other thiazides followed—with improvements being aimed at two particular areas: 1. attempts to increase diuretic action in relation to the milligram potency of the drug, and 2. attempts at a more favorable sodium/potassium ratio in the urine, i.e., to decrease the excretion of potassium while maintaining the excretion of sodium.¹²

One of these, Naturetin, Squibb Bendroflumethiazide, has made advances on both these points. "By adding a 3-benzyl radical to hydroflumethiazide a rather dramatic reduction in dose range is accomplished. With this drug, effective sodium excretion is obtained with

doses between 2.5 and 10 mg., which is a 200 to 1 ratio as compared to chlorothiazide..."¹³

Moreover, due probably to its virtual lack of carbonic anhydrase inhibition Naturetin (bendroflumethiazide) has been shown to cause less potassium and bicarbonate loss and less alteration in urinary pH than either chlorothiazide or hydrochlorothiazide.

Naturetin is outstandingly effective not only in establishing, but also in maintaining, excretion of retained fluid in edematous patients. And its duration of action is sufficiently prolonged to allow a single daily administration in most patients. Naturetin is also an effective antihypertensive agent.

Contraindications: Severe renal impairment, previous hypersensitivity.

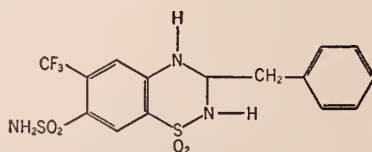
Warning: Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting, or G.I. bleeding occur.

Precautions: The dosage of ganglionic blocking agents, veratrum, or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Electrolyte disturbances are possible in cirrhotic or digitalized patients.

Side Effects: Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, and rashes may occur.

Supplied: Naturetin (Squibb Bendroflumethiazide) 5 mg. and 2.5 mg. tablets. Also available Naturetin \bar{c} K [Squibb Bendroflumethiazide (5 or 2.5 mg.) with Potassium Chloride (50 mg.)]. For full information, see Product Brief.

References: 1. Southworth, H.: *Proc. Soc. Exper. Biol. & Med.* 36:58, 1937. 2. Mann, and Keilin, D.: *Nature* 146:164, 1940. 3. Pitt R. F., and Alexander, R. S.: *Am. J. Physiol.* 144:239, 1945. 4. Schwartz, W. B.: *New England J. Med.* 240:173, 1949. 5. Friedberg, C. K., in Moyer, J. H., and Fuchs, M.: *Edema: Mechanisms and Management*, Philadelphia: W. B. Saunders Co., 1960, p. 259. 6. Cummings, J. R.; Tabachnick, E., and Seelig, M., Moyer, J. H., and Fuchs, M.: *op. cit.*, p. 25. 7. Werko, L., in Moyer, J. H., and Fuchs, M.: *op. cit.*, p. 188. 8. Beyer, K. H., Jr., in Moyer, J. H., and Fuchs, M.: *op. cit.*, p. 274. 9. Mare T. H., and Wiley, C. E.: *J. Pharmacol. Exper. Therap.* 143:230, 1964. 10. Earle L. E., and Orloff, J.: *Ann. Rev. Med.* 15:14, 1964. 11. Fuchs, M., and Mallin, S. R., Moyer, J. H., and Fuchs, M.: *op. cit.*, p. 27. 12. Ford, R. V., in Moyer, J. H., and Fuchs, M.: *op. cit.*, p. 290. 13. cited in Fuchs, M., and Mallin, S. R. (ref. 11): *op. cit.*, p. 283.



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to reduce excess fluid
or high blood pressure

SQUIBB



"The Priceless Ingredient" of every product is the honor and integrity of its maker.



Government News

Artificial Heart Development Contracts Awarded by National Heart Institute

The National Heart Institute, a component of the Public Health Service, U. S. Department of Health, Education, and Welfare, has awarded 15 new contracts totalling \$3,090,284 to 12 institutions for research aimed at the solution of specific problems in artificial-heart development.

Seven of the contracts will support research seeking materials that provide the combination of physical and chemical properties most desirable for artificial-heart construction.

Three contracts will support studies on the effects of extra heat on blood, tissues, organs, and their physiological functions in order to establish what levels of heat generated by an artificial-heart power source could be safely tolerated by the body.

Two contracts will be concerned with evaluating effects of various blood pumps on blood pressure and flow, on red blood cells and other formed

elements of blood, on blood chemistry, and on the functions of various organs.

Two contracts will provide for refinement and limited production of those assist devices now ready for further evaluation, so that these models can be supplied to research teams for further testing.

The final contract provides for research to determine the feasibility of an implantable fuel cell as a potential power source for the artificial heart.

This group of awards increases to 32 the total number of contracts let by the Artificial Heart Program since June 1964, when NHI launched an expanded program of research and development to make circulatory-assist devices and, eventually, total heart replacements a clinical reality within the shortest possible time.

Waste Disposal Training Offered

The American Public Works Association has agreed to prepare courses for training solid waste disposal operating personnel under a \$65,500 contract with the Public Health Service Office of Solid Wastes, Department of Health, Education, and Welfare.

The Association plans to conduct training programs through its local chapters after curricula for the courses have been developed, said Wesley E. Gilbertson, Chief of the Office of Solid Wastes.

The APWA project, Gilbertson said, is one of several moves now being made to correct a critical trained manpower shortage as one phase of a national waste disposal improvement program

designed to reduce health hazards and environmental blight caused by improper handling of garbage, trash, and debris.

Courses to be developed by APWA will supplement solid wastes training for graduate engineers now being supported by Office of Solid Wastes grants at four institutions of higher learning and short-term instruction at the Public Health Service's Sanitary Engineering Center at Cincinnati, Ohio.

The training project will be in direct charge of Robert D. Burgher, executive director of APWA. The Association's headquarters are in Chicago, Illinois.

Radioactive Material Transport Revisions

The Atomic Energy Commission has approved a revision of its regulations on the safe transportation of licensed radioactive material.

The revision incorporates performance standards for shipping containers and for packing and shipping the fissile materials uranium 233, uranium 235, and plutonium. Standards include a minimum of detail on required packaging specifications. Emphasis has been placed on performance standards to provide the needed flexibility to develop improved shipping methods. The scope of the regulation has been extended to apply these same standards to large quantities of other licensed radioactive material, such as radioisotopes, in addition to fissile material. Performance standards are compatible with those developed by the International Atomic Energy Agency during the past few years.

The safety record in the shipment of radioactive material has been extremely good. The Commission's purpose in revising its regulations

is to assist in maintaining the high degree of safety which has been experienced in the past.

Shipment of radioactive material also is subject to the regulations of other federal agencies, including the Interstate Commerce Commission, the Coast Guard, the Federal Aviation Agency and the Post Office Department. The AEC is coordinating its regulatory control in this area with these other agencies.

In a "Memorandum of Understanding" between AEC and ICC signed on March 21, the agencies agreed that AEC will adopt regulations applicable to preparation for shipment of fissile material and large quantities of radioactive material and, as necessary, for radioactive material when its shipment is outside the jurisdiction of ICC. ICC will adopt regulations, consistent with AEC standards, on transport of all radioactive material and on preparation for shipment of radioactive material other than fissile material and large quantities of radioactive material.

For the treatment of
**apathy
irritability
forgetfulness
confusion**
in the aging patient

EACH CEREBRO-NICIN CAPSULE CONTAINS:

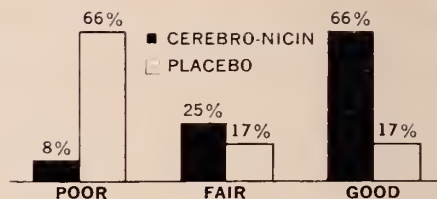
Pentamethylene Tetrazole	100 mg.
Nicotinic Acid	100 mg.
Ascorbic Acid	100 mg.
Thiamine HCl	25 mg.
L-Glutamic Acid	50 mg.
Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine	2 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.
AVAILABLE: Bottles of 100, 500, 1000 capsules.
Also elixir pint bottles.

CONTRAINDICATIONS: There are no known contraindications to Pentamethylene Tetrazole although caution should be exercised when treating patients with a low convulsive threshold. Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.
Federal law prohibits dispensing without a prescription.

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A GENTLE CEREBRAL STIMULANT AND VASODILATOR



CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

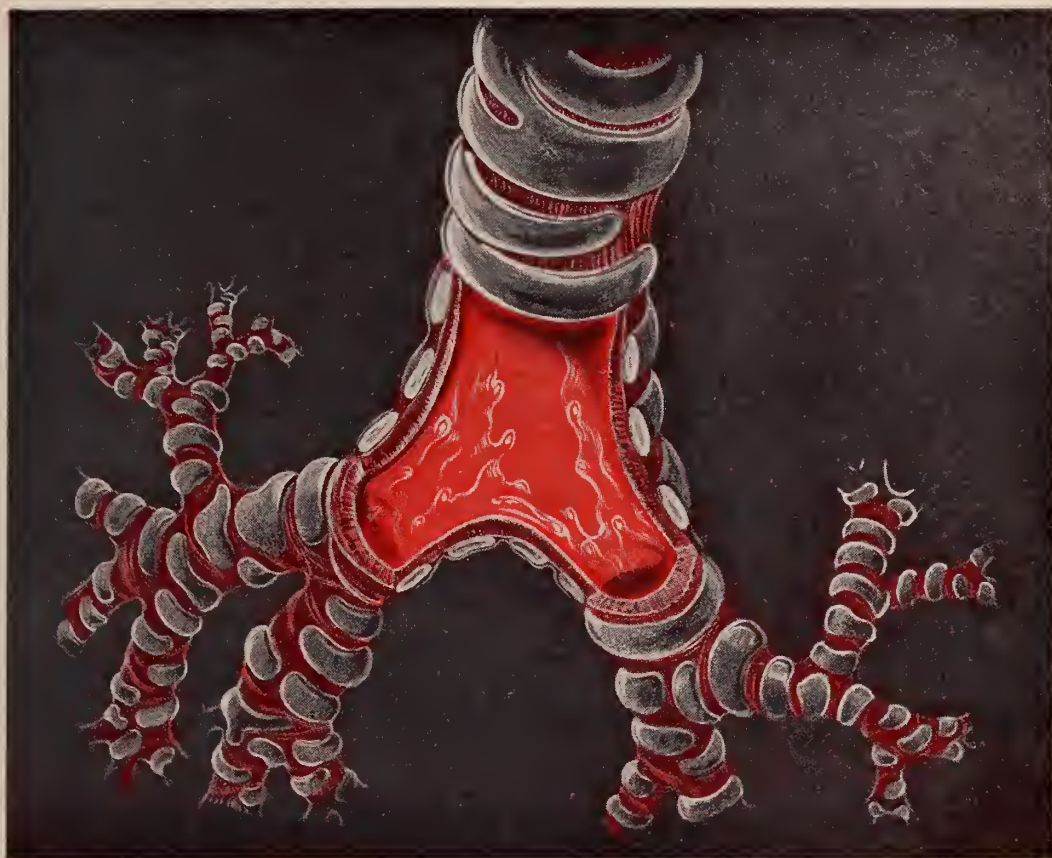
*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jnl. of the Amer. Ger. Soc., June, 1964.

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ACTIVATE MUCUS LIQUEFACTION in Bronchitis, Sinusitis, Asthma with well-tolerated **IDO-NIACIN**®

Each Slosol coated tablet contains
Potassium Iodide 135 mg. and
Niacinamide Hydroiodide 25 mg.

Taste-free Iodo-Niacin provides mucus liquefying KI in a palatable form which on prolonged use greatly reduces the possibility of iodism.

In *The Pharmacologic Basis of Therapeutics*, Goodman and Gilman affirm, "Iodide salts are useful expectorants when it is desired to liquefy tenacious bronchial secretions, for example, in the later states of bronchitis, bronchiectasis, and asthma." Ed. 3, New York, Macmillan, 1965, p. 815.

When discussing symptomatic therapy of status asthmaticus, Hildreth recently stated, "There is little evidence that any expectorant other than potassium iodide is of practical value in this situation." Hildreth, E. A., *Postgrad. Med.*, 38:460 (Nov.) 1965.

When Iodo-Niacin was used for iodide therapy

continuously for over one year, symptoms of iodism were predominantly absent or of minor extent.

Dosage and how supplied: Adults—two tablets after meals taken with water. Children over eight years—one tablet after meals with water. Available in bottles of 100.

Caution: Serious side effects from Iodo-Niacin are rare. Caution is recommended in persons with known sensitivity to iodides. Pulmonary tuberculosis is considered a contraindication to the use of iodides by some authorities, and should be used with caution in such cases. As with all drugs, Iodo-Niacin may cause an idiosyncrasy in some patients. Rare cases of goiter with hypothyroidism have been reported in adults and in newborn infants of mothers taking iodides for prolonged periods. Use appropriate precaution in pregnancy and in individuals receiving Iodo-Niacin for prolonged periods.



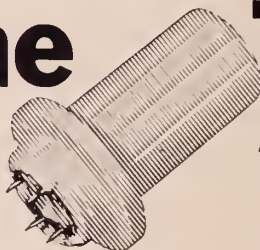
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in
chewable
tablets

in granules
for oral
suspension

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therapy is indicated...



CONSIDER: an exceptionally high cure rate in susceptible infections

The rationale: When combined, Erythrocin and the trisulfapyrimidines (triple sulfas) are indicated in infections that are more susceptible to the combination than to either agent alone. Such conditions are usually found in urinary, lower respiratory tract and chronic ear conditions.

The results: Clinical studies involving 142 young patients showed *an overall cure rate of*

96.5%. Side effects were experienced by only four of the patients.

The acceptance: The majority of the 142 patients studied expressed a definite liking for the products. *There were only two refusals.* An independent taste-test with 50 healthy children further substantiated the excellent acceptability of the orange-flavored forms.

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ERYTHROCIN®-SULFAS
ERYTHROMYCIN ETHYL SUCCINATE-TRISULFAPYRIMIDINES

In Chewable Tablets
In Granules for Oral Suspension



ERYTHROCIN®-SULFAS

Brief Summary

Indications: Use Erythrocin-Sulfas in infections more susceptible to the combination than to either agent alone. These are usually found in urinary, lower respiratory tract, and chronic ear infections.

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or new born infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions: Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

If a reaction or overgrowth of nonsusceptible organisms occurs, withdraw the drug.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. each of sulfadiazine, sulfamerazine and sulfamethazine. 603303



Meetings

September

- 16-17 Fall meeting, "Care of Aging," Florida Division, International College of Surgeons, University Inn, Gainesville.
- 16-17 Otolaryngology Seminar, University of Florida, Gainesville.
- 17-18 Fifth Annual Physician's Seminar on Respiratory Diseases, Florida Tuberculosis and Respiratory Diseases Association, Diplomat Hotel, Hollywood.
- 22-24 Cardiovascular Seminar, University of Florida, Gainesville.
- 29-30 Seminar on Diabetes, Florida Diabetes Association, Deauville Hotel, Miami Beach.

October

- 14-15 Fall meeting, Florida Orthopedic Society, Pier 66, Fort Lauderdale.
- 20-22 "Industrial Medicine, The Doctors Role in Occupational Health," Mound Park Hospital Auditorium, St. Petersburg.
- 27-29 Neurology-Neurosurgery Seminar, University of Florida, Gainesville.

November

- 10-12 Pediatric Seminar, University of Florida, Gainesville.
- 17-18 Obstetrics and Gynecology Seminar, University of Florida, Gainesville.
- 17-19 "Pediatric Neurology," Florida Pediatric Society Fall Meeting, Beach Club Hotel, Ft. Lauderdale.

December

- 1-3 "The Lower Extremity Amputee—Surgery and Prosthetic Management," University of Miami, Americana Hotel, Miami Beach.
- 9-11 Joint meeting, Florida Society of Ophthalmology and Florida Society of Otolaryngology and Maxillofacial Surgery, Lucayan Beach Hotel, Freeport, Grand Bahama Island.

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One such drug—INDOCIN® (indomethacin), a nonsteroid, anti-inflammatory agent fundamentally different in structure and activity from other drugs in use—was recently made available for the treatment of arthritic conditions. It opens new possibilities for the long-term management of arthritis and inflammatory disease.



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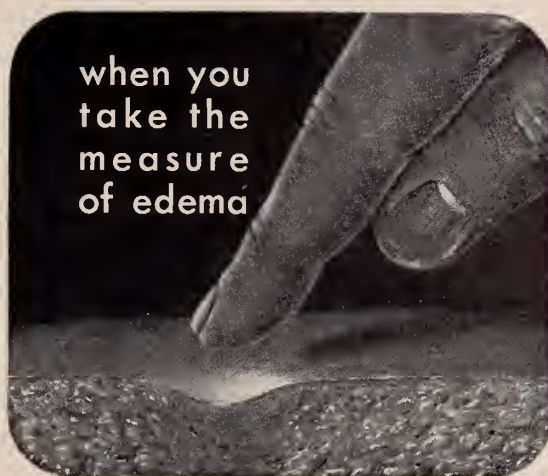
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INDOMETHACIN

Indications: Chronic and acute rheumatoid arthritis, rheumatoid (ankylosing) spondylitis, degenerative joint disease (osteoarthritis) of the hip, and gout. **Contraindications:** Active peptic ulcer, gastritis, regional enteritis, or ulcerative colitis. Safety in pregnancy has not been established. Not recommended for pediatric age groups.

Warning: Patients who experience dizziness, lightheadedness, or feelings of detachment on INDOCIN should be cautioned against operating motor vehicles, machinery, climbing ladders, etc. Use cautiously in patients with psychiatric disturbances, epilepsy, or parkinsonism.

Precautions and Adverse Reactions: Most commonly, headache, dizziness, lightheadedness, G.I. disturbances. The C.N.S. effects are often transient and frequently disappear with continued treatment or reduced dosage. The severity of these effects may occasionally require cessation of therapy. G.I. effects may be minimized by giving the drug with food or with antacids or immediately after meals. Ulceration of the stomach, duodenum, or small intestine has been reported and, in a few instances, severe bleeding with perforation and death. Gastrointestinal bleeding with no obvious ulcer formation has also been noted; INDOCIN should be discontinued if G.I. bleeding occurs. As a result of G.I. bleeding, some patients may manifest anemia, and for this reason periodic hemoglobin determinations are recommended. Rare reports of effects not definitely known to be attributable to INDOCIN include bleeding from the sigmoid colon (either from a diverticulum or without a known previous pathologic condition), perforation of preexisting sigmoid lesions (diverticulum, carcinoma), and hematuria. In other rare cases, a diagnosis of gastritis has been made while the drug was being given. One patient developed ulcerative colitis, and another, regional ileitis, while receiving INDOCIN; when the drug was given to patients with preexisting ulcerative colitis, there was an increase in abdominal pain. Infrequently observed side effects may include drowsiness, tinnitus, mental confusion, depression and other psychic disturbances, blurred vision, stomatitis, pruritus, edema, and hypersensitivity reactions. Slight BUN elevation, usually transient, has been seen in some patients, although the preponderance of evidence indicates that INDOCIN does not adversely affect renal function, even in patients with preexisting renal disease. Nevertheless, renal function should be checked periodically in patients on long-term therapy. Leukopenia has been seen in a few patients. Transient elevations in alkaline phosphatase, cephalin-cholesterol flocculation, and thymol turbidity tests have been observed in some patients and, rarely, elevations of SGOT values; the relationship of these changes to the drug, if any, has not been established. As with any new drug, patients should be followed carefully to detect unusual manifestations of drug sensitivity. **Before prescribing or administering, read product circular with package or available on request.**



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AQUATAG (Benzthiazide) is a potent, orally active, nonmercurial, diuretic agent. It is effective orally in producing diuresis in edema states, where it is therapeutically comparable to mercurials given parenterally. AQUATAG (Benzthiazide) is mildly antihypertensive in its own right and enhances the action of other antihypertensive drugs when used in combination.

DIURETIC ACTION: Clinically, the oral administration of AQUATAG (benzthiazide) results in diuretic activity within two hours with maximal natriuretic, chloruretic, and diuretic effects occurring during the fourth, fifth and sixth hours. Maintenance of response continues for approximately 12 to 18 hours. Acidosis is an unlikely complication since therapeutic doses of AQUATAG (benzthiazide) do not appreciably increase bicarbonate excretion. Edematous patients receiving 50 mg. of AQUATAG (benzthiazide) daily for five days developed a maximal increase in the rate of sodium excretion on the first day, and maintained this high rate until depletion of excessive body stores of sodium.

In congestive heart-failure patients, AQUATAG (benzthiazide) produced the same weight loss during a 48-hour treatment period as did a maximally effective dose of hydrochlorothiazide.

DOSAGE: Diuresis, initially 50 to 200 mg.; maintenance 25 to 150 mg. daily. Hypertension 50 to 100 mg. initially, adjusted to 50 mg. t.i.d. or downward to minimal effective dosage level.

WARNINGS: Use with caution in the presence of renal disease as azotemia may be precipitated or increased. In patients with advanced hepatic disease, electrolyte imbalance may result in hepatic coma. Dosage of coadministered antihypertensive agents should be reduced by at least 50%. In cases of suspected electrolyte imbalance, serum electrolyte determinations should be performed and imbalance, if any, corrected. Stenosis or ulcer of small intestine have been reported with coated potassium formulas, and surgery has been required and deaths have occurred. Based on surveys of both United States and foreign physicians, incidence of these lesions is low and a causal relationship in man has not been definitely established. Until further experience has been obtained, the use of the drug in pregnant patients should be weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or dysfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties. Severe hepatic disease is a relative contraindication. (See "Warnings" above.)

PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia (digitalis toxicity may be precipitated), hypochloremic alkalosis and hyponatremia may occur. Patients with cirrhosis should be observed for impending hepatic coma and hypokalemia. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Hepatic fetor, tremor, confusion and drowsiness are signs of impending pre coma and coma in patients with cirrhosis. Insulin requirements may be altered in diabetes. AQUATAG (benzthiazide) should be used with caution post operatively as hypokalemia is not uncommon. Potassium supplementation may be advisable pre- and post operatively. There have been occasional reports of thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia and precipitation of acute pancreatitis or jaundice.

Before prescribing or administering, read the package insert or file card available on request.

Available as 25 or 50 mg. scored tablets.

Request clinical samples and literature on your letterhead.



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& COMPANY**
Detroit, Michigan 48234

There is nothing Detroit about it.



Porsche is built for people who like to drive. The only push buttons you can get are the ones on the radio. And the radio is optional.



No push buttons here

The rest is pure GT. The features that make it a winner at Sebring and LeMans make it exciting to drive in open country or city traffic.

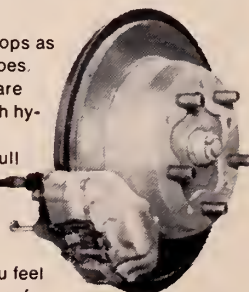
No Detroit wheels hug a rough road like Porsche. We introduced torsion bar

suspension 17 years ago. We've been improving it ever since.

The fast 4-speed gearbox (5-speed if you want it) shifts smooth as an automatic. But response is immediate. And powerful.

The rack and pinion steering is direct and precise. When you turn the wheel, the car responds — instantly. You're in complete control. Always. At any speed, on any surface.

Porsche stops as surely as it goes. All 4 wheels are equipped with hydraulic disc brakes that pull the speed down evenly and are virtually fade-free. You feel safe. You are safe.



Disc brakes all 4 wheels

As one commuter put it, "Porsche is the kind of car that makes you wish you lived further from work." Nothing Detroit about that.



Sunday driver

PORSCHE

Porsche 911. 6 cylinder engine, 148 horsepower, 5-speed synchromesh, top speed 130 mph.

Porsche 912. 4 cylinder engine, 102 horsepower, 4 speed synchromesh (5-speed optional), top speed 115 mph.



following infection

B and C vitamins are therapy: STRESSCAPS B and C vitamins in therapeutic amounts...help the body mobilize defenses during convalescence...aid response to primary therapy. The patient with a severe infection, and many others undergoing physiologic stress, may benefit from STRESSCAPS capsules.



Stresscaps[®]

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Each capsule contains:

Vitamin B ₁ (as Thiamine Mononitrate)	10 mg
Vitamin B ₂ (Riboflavin)	10 mg
Vitamin B ₆ (Pyridoxine HCl)	2 mg
Vitamin B ₁₂ Crystalline	4 mcgm
Vitamin C (Ascorbic Acid)	300 mg
Niacinamide	100 mg
Calcium Pantothenate	20 mg

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

When uncontrolled diarrhea brings a call for help



When the diarrhea sufferer has run the gamut of home remedies without success, pleasant-tasting CREMOMYCIN can answer the call for help. It can be counted on to consolidate fluid stools, soothe intestinal inflammation, inhibit enteric pathogens, and detoxify putrefactive materials — usually within a few hours.

CREMOMYCIN combines the bacteriostatic agent succinylsulfathiazole and neomycin, with the adsorbent and protective demulcents, kaolin and pectin, for comprehensive control of diarrhea.

INDICATIONS: Diarrhea.

CONTRAINDICATIONS: Do not use in intestinal obstruction, extensive ulceration of bowel, or diverticulosis; in hypersensitivity to sulfonamides or neomycin; in pregnancy at term, in premature infants, or during first week of life in the newborn.

WARNINGS: Use only after critical appraisal in patients with hepatic or renal damage, urinary obstruction, or blood dyscrasias. Fatal hypersensitivity reactions and blood dyscrasias reported with use of sulfonamides. Consider periodic blood counts, hepatic and renal function tests during intermittent or chronic use.

PRECAUTIONS: *Succinylsulfathiazole:* Use with caution if there is history of significant allergies and/or asthma. Continued use requires supplementary vitamins B₁ and K. *Neomycin:* Watch

your Rx for
Cremomycin
can provide relief



-like neuromuscular block during anesthesia if neomycin
d preoperatively in large doses when renal function is
watch for overgrowth of nonsusceptible organisms. Con-
possibility of ototoxicity and nephrotoxicity with prolonged
usage.

EFFECTS: As with all sulfonamides: Headache, malaise, an-
G.I. symptoms, hepatitis, pancreatitis, blood dyscrasias,
pathy, drug fever, rash, conjunctival and scleral injection,
iae, purpura, hematuria, and crystalluria have been noted.
ed fecal output of thiamine and decreased synthesis of
n K have been reported. *Neomycin:* Nausea, loose stools.

prescribing or administering, read package circular with
ct or available on request.

emptly relieves diarrheal distress

Cremomycin[®]
TIDIARRHEAL

osition: Each 30 cc. contains neomycin sulfate 300 mg.
alent to 210 mg. of neomycin base), succinylsulfathiazole
n., colloidal kaolin 3.0 Gm., pectin 0.27 Gm.

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re today's theory is tomorrow's therapy

NEWS

Toxicology Conference Held In Miami

The Fifth Inter-American Conference on Toxicology and Occupational Medicine was held Aug. 1-4 at the Dupont Plaza Hotel, Miami.

Sponsored by the University of Miami School of Medicine with the assistance of the University of Puerto Rico School of Medicine, the program highlighted a symposium on bladder cancer, a first in the history of U. S. medicine, according to the UM news bureau.

A number of scientific papers under the headings Toxicology, Pesticides and Occupational Medicine were presented.

UF Surgical Conferences

University of Florida surgery conferences for the new school year began July 9.

Clinical conferences, held every Saturday at 9:50 a.m., are strongly oriented toward clinical surgery and consist of case presentations from the various UF surgical services.

For those interested in general surgery, surgical-pathology conferences will be held Saturday mornings from 8:30 to 9:30.

Civitan President Speaks In Florida

Dr. John R. Pate, president of Civitan International, spoke before a press luncheon held June 23 prior to the Civitan annual convention at the George Washington Hotel in Jacksonville. He spoke on the meaning of Civitan International and the past and planned accomplishments of this service club.

Dr. Pate, of Arlington, Virginia, the seventh physician to serve as president of Civitan International, is director of the Bureau of Disease Control of the District of Columbia Health Department. In addition to a B.S. and an M.D., he has also earned an A.M., an A.B., an M.P.H., an LL.B. and a Certificate in Hospital Administration.

Dr. Pate's wife, professionally known as Dr. Alice Chenoweth, is a practicing pediatrician and first vice president of the American Medical Women's Association.

Civitan International was founded by a physician—Dr. Courtney W. Shropshire, a urologist and graduate of the University of Tennessee College of Medicine. Dr. Shropshire passed away during the spring of 1965.

It was mentioned at the press luncheon that the Jacksonville branch is the second largest Civitan group in the United States and Canada.

ECG by Telephone Now Available

A series of data sets, recently developed by Bell Telephone Laboratories, makes it possible to dial a connection and transmit electrocardiograms over the telephone network.

The new series, designated 603 type, allows transmission of an ECG from a physician's office or from a patient's bedside.

FSVMA Holds Annual Meeting

FMA members are invited to attend the 1966 annual meeting of the Florida State Veterinary Medical Association, September 25-27, Daytona Plaza Hotel, Daytona Beach.

An outstanding scientific program of interest to all physicians and veterinarians has been assembled, according to officers of the FSVMA. Among subjects being highlighted are new developments in orthopedics, radiology, anesthesia, suture techniques and canine ophthalmology. Several internationally and nationally known speakers will be featured.

Physicians will be admitted to all sessions at no charge upon presentation of their FMA membership card. Further details and advance registration may be obtained by contacting Charles Bild, D.V.M., FSVMA program chairman, Bild Animal Hospital, 2500 N.W. 79th Street, Miami 33147.

New Film Features Depression Scale

A film depicting the development, validation and use of a scale for the quantitative measurement of depression is now available for medical educational purposes.

The scale was designed by Dr. William Zung, a psychiatrist of Durham, N. C. Although initially devised for use in psychiatric research, the scale readily lends itself to the general practice of medicine where most depressions are first encountered.

The self-rating scales, available in quantity for use in office practice, come complete with full instructions. Both the film and pads of the scale are available free upon request from Lakeside Laboratories, Inc., Milwaukee, Wisconsin 53201.

UF Physicians Selected For Research Awards

Three physicians in the University of Florida College of Medicine received Research Career Development awards from the National Institutes of Health.

The awards were granted the UF on behalf of Dr. Daniel Belkin, instructor in physiology; Dr. Hiram Kitchen, assistant professor in the departments of medicine and biochemistry, and Dr. Nikaan Andersen, assistant professor of anesthesiology.

The awards will enable the UF to finance positions for qualified young scientists who have demonstrated a capacity for independent research. The development awards cover a five-year period.

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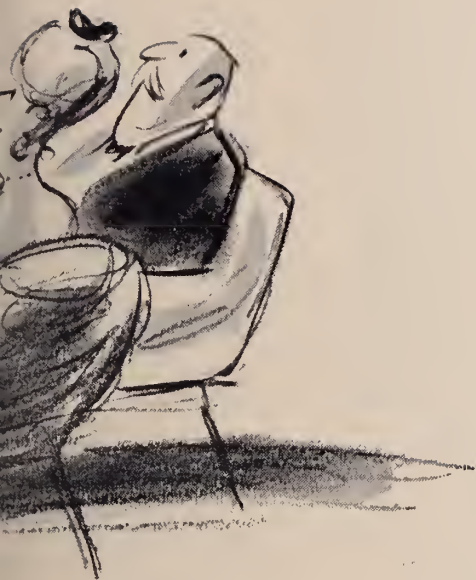
Physician Needed

Position open for Florida licensed physician to practice in progressive residential community for active older persons. Administrative and professional responsibilities for outpatient clinic and 32-bed nursing home. Round the clock RNs. Excellent working conditions and facilities. Desirable personnel practices and fringe benefits. Attractive independent staff housing. Community borders Atlantic Ocean. In Palm Beach County. Salary based on demonstrated ability and experience. Let me tell you more about this interesting position.

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It's a Mrs. Smith, Doctor Harris. Something about postnasal drip.

When you're called upon to provide quick relief for the sinusitis patient, Novahistine Singlet will usually do the job.

A single tablet provides prompt analgesic effect for relief of sinusitis pain. Then Novahistine Singlet also attacks the underlying cause of the headache—helping to open blocked respiratory passages and restore normal sinus drainage. The continuous decongestant effect produced by one Novahistine Singlet every 8 hours helps reduce the chance of acute sinusitis progressing to chronic stages.

Use cautiously in patients with severe

hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that Novahistine may occasionally cause drowsiness. Each tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.

NOVAHISTINE[®] SINGLET^(TM)

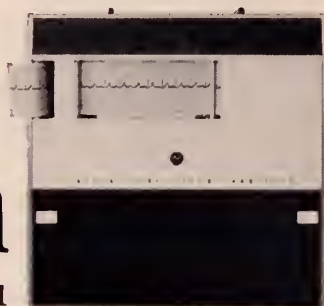
For relief of sinusitis pain and congestion.



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if you've ever had to hunt for
your ECG cables, straps, electrodes
...pull out the wall plug
and reverse it...struggle with
paper that wouldn't thread
...or needed a faster chart
speed or different sensitivity...

then
you
should have a 500 Viso
to save you time.



All electrodes, straps, Redux Creme and cables store conveniently inside 500 Viso.



Reverse power line polarity on 500 by pushbutton.



Reload Permapaper chart rolls with no threading, in seconds (one roll makes 25 12-lead tests).



All 500 Viso's have 25 and 50 mm/sec. chart speeds ... 1/2, 1 or 2X sensitivity settings for optimum trace amplitude.

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Measuring for Medicine and the Life Sciences



Breast-feeding and the “modern mother”

Despite a mild resurgence of interest in the importance of breast-feeding a few years ago, many women today do not choose to nurse their young. This is for a variety of reasons—social, economic, cultural and sometimes medical. In such cases the physician's task is to find the most suitable means of preventing lactation and easing the pain of breast engorgement.

The means of therapy

The value of hormone therapy for this indication is of course well established. Both androgen and estrogen are known to inhibit the production and secretion of the lactogenic hormone by the anterior pituitary. As estrogen levels decline sharply at parturition, lactogenesis is established. When androgen and estrogen are administered to the patient before the release of the lactogenic hormone lactation and breast engorgement are usually prevented.

The time of therapy

The time of administration of this combined medication is crucial; it must be given early enough to suppress the pituitary prolactin and last long enough to permit physiologic readjustment during the puerperium. Excellent results are most often seen when therapy is administered before the onset of the second stage of labor.

However, factors other than effectiveness must also be considered. The agent selected should not interfere in any way with parturition, subsequent uterine involution and the restoration of normal ovarian cyclic function. Furthermore, it should not cause rebound breast engorgement or other manifestations of hormonal imbalance.

A balanced formulation

Providing single-dose therapy for the prevention of lactation and breast engorgement, Deladumone OB is a potent androgen-estrogen combination with a prolonged action. The optimal balance of androgenic and estrogenic hormones achieved in this preparation minimizes the disadvantages inherent in single hormone therapy, such as rebound breast engorgement. Involution of the uterus and resumption of menstrual cycles are not affected.

As reported in a recent published study (Roser, D. M.: *Obstet. & Gynec.* 27:73, 1966), Deladumone OB provided good suppression of breast engorgement in 95.3% and suppression of lactation in 81.1% of 86 obstetrical patients. These results are in general agreement with those of many earlier investigations; in several studies this injectable androgen-estrogen combination proved to be superior to oral medication.

Dosage:

As a single injection of 2 cc. before the onset of the second stage of labor.

Contraindications:

Established or suspected mammary cancer or genital malignancy.

Precautions and Side Effects:

Certain patients may be unusually responsive to either estrogenic or androgenic therapy. In such individuals virilization, uterine bleeding or mastodynia may occur.


Supply:

Deladumone OB, providing 180 mg. testosterone enanthate and 8 mg. estradiol valerate per cc., is available in 2 cc. Unimatic® disposable syringes and in 2 cc. vials. Both preparations are dissolved in sesame oil, with 2% benzyl alcohol as a preservative. *Before use, consult product literature for full prescribing information.*

Deladumone® OB

Squibb Testosterone Enanthate (180 mg./cc.)
and Estradiol Valerate (8 mg./cc.)

Single-dose injection for lactation inhibition

SQUIBB  *"The Priceless Ingredient" of every product
is the honor and integrity of its maker.*



The “Socio- geographic” mystery

Why is one man's gastric ulcer another man's duodenal?



Geographic variation in the *incidence* of peptic ulcer is a familiar fact. But the proclivity of certain *kinds* of ulcer for certain geographic areas is a recently recognized phenomenon.^{1,2}

For example, in one particular Norwegian fishing village there is a tendency for patients to develop a gastric ulcer; anywhere else in Norway, ulcers are usually duodenal. Peruvians high in the Andes have more gastric ulcers than their compatriots in the lowlands. Why? Nobody knows.

Social variations, too. Even in the same geographic areas there are interesting variations. An Englishman's ulcer depends on his social standing—professional men suffer with duodenal ulcers, while workingmen have more of the gastric variety. In southern India the pattern is reversed. Here, duodenal ulcers are common among laborers and agricultural workers and rare among the upper classes.

Investigators are exploring every possible theoretical avenue in their search for the cause of peptic ulcer. Of all the factors implicated in ulcerogenesis, the one that is generally acknowledged to be of primary importance is hypersecretion of gastric acid.³⁻⁸ Or, as one author states it: "The medical management of peptic ulcer pharmacologically is, in the final analysis, concerned largely with the effective inhibition of peptic activity."³

Robinul (glycopyrrolate) provides potent, rapid, specific antisecretory action as confirmed by gastric analyses and x-ray evidence of clinical effectiveness.^{3,7,9-12} It relieves pain with "impressive" promptness.⁸ Quickly alleviates acute discomfort, and effectively counteracts gnawing pain, preprandial midepigastric pain, burning and other ulcer symptoms.⁷ Suppression of nocturnal pain is "outstanding."¹³ Maximally effective doses may be given with minimal side effects, and the incidence of unwanted anticholinergic effects is negligible.^{3,7-14}

No matter what the ulcer theory...the fact is that

Robinul[®]

(glycopyrrolate)

Promotes the essential ulcer-healing environment

H-ROBINS

(brief summary follows)

Robinul® (glycopyrrolate)

**promotes the
essential ulcer-healing
environment**

Indications: In addition to its primary indications for duodenal and gastric ulcer, Robinul (glycopyrrolate) is indicated for other GI conditions that may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.

Contraindications: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.

Precautions: Administer with caution in the presence of incipient glaucoma.

Adverse Reactions: Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

Dosage: Dosage should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet 3 times a day: in the a.m., early p.m., and at bedtime. *See product literature for full prescribing information.*

Supply: Robinul (glycopyrrolate 1 mg.); Robinul Forte (glycopyrrolate 2 mg.); Robinul-PH (glycopyrrolate 1 mg.) with phenobarbital 16.2 mg. (Warning: May be habit-forming); Robinul-PH Forte (glycopyrrolate 2 mg.) with phenobarbital 16.2 mg. (Warning: May be habit-forming.) In bottles of 100 and 500 scored tablets.

References: 1. Jones, F. A., and Gummer, J. W. P.: *Clinical gastroenterology*, Springfield, Ill., Charles C Thomas, 1960, pp. 322-3. 2. Bockus, H. L.: *Gastroenterology*, 2nd ed., vol. I, Philadelphia, Saunders, 1963, p. 468. 3. Sun, D. C. H.: *Ann NY Acad Sci* 99:153 (Feb. 28) 1962. 4. Moore, V. A.: *Postgrad Med* 38:216 (Sept.) 1965. 5. Dragstedt, L. R., Woodward, E. R., Storer, E. H., Oberhelman, H. A., Jr., and Smith, C. A.: *Ann Surg* 132:626 (Oct.) 1950. 6. Posey, E. L., Jr., Smith, P., Turner, C., and Aldridge, J.: *Amer J Dig Dis* 10:399 (May) 1965. 7. Lamphier, T. A., Siegel, L., and Goldberg, R. I.: *Amer J Gastroent* 37:551 (May) 1962. 8. Kasich, A. M., and Fein, H. D.: *Ibid* 39:61 (Jan.) 1963. 9. Epstein, J. H.: *Ibid* 37:295 (Mar.) 1962. 10. Moeller, H. C.: *Ann NY Acad Sci* 99:158 (Feb. 28) 1962. 11. Slinger, A.: *J New Drugs* 2:215 (Jul.-Aug.) 1962. 12. Barman, M. L., and Larson, R. K.: *Amer J Med Sci* 246:325 (Sept.) 1963. 13. Shutkin, M. W.: *Amer J Gastroent* 38:682 (Dec.) 1962. 14. Flesher, B.: *J New Drugs* 2:211 (Jul.-Aug.) 1962. A. H. ROBINS CO., INC.
Richmond, Virginia

Books

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Here is the Abbott anorectic program designed to meet the individual needs of your overweight patients.



mood elevation

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Program

DESOXYN® Gradumet® (methamphetamine hydrochloride)

Smooth appetite control plus mood elevation.

The obese patient on a diet often has to battle depression as well as overweight. Desoxyn Gradumet helps the dieter in both battles by elevating the mood while it curbs the appetite. Thanks to the Gradumet, medication is smoothly released all-day from a single oral dose.

If she can't take plain amphetamine, put her on DESBUTAL® Gradumet

Calms anxieties; controls compulsive eating.

Desbutal Gradumet provides 2 drugs in 2 tablet sections, combined back to back to form a single tablet. One section contains Desoxyn to curb the appetite and lift the mood; the other contains Nembutal® (pentobarbital) to calm the patient and counteract any excessive stimulation.

Both drugs are released in an effective dosage ratio throughout the day.



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Anorectic
Program

Not all long-release vehicles are the same. Here is why the Gradumet is different and what it means for your overweight patients.



The release action is purely physical and relies on only one factor common to every patient: gastrointestinal fluid. There is no dependence on enteric coatings, enzymes, motility, or an "ideal" ion concentration in the gastrointestinal tract.

Your patients get a measured amount of medication, moment by moment, throughout the day.

They are not subjected to ups and downs of drug release . . . or to erratic release from patient to patient . . . or to erratic release in the same patient from day to day.

That's why the Gradumet provides controlled-release as well as long release.



Perhaps you saw the Gradumet model demonstration which shows that the release is entirely physical. When fluid is added, the drug in the outer ends of the channels dissolves. As fluid penetrates deeper into the channels, there is a continuous release of medication. The rate of release is rigidly controlled by the size and number of channels.

choice of 5 strengths

Abbott
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Program

DESOXYN Gradumet

Methamphetamine Hydrochloride in Long-Release Dose Form



5 mg.



10 mg.



15 mg.

DESBUTAL 10 Gradumet

10 mg. Methamphetamine Hydrochloride,
60 mg. Pentobarbital Sodium



Front



Side

DESBUTAL 15 Gradumet

15 mg. Methamphetamine Hydrochloride,
90 mg. Pentobarbital Sodium

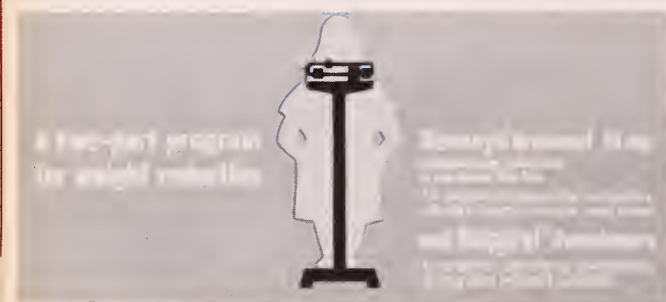


Front



Side

samples available



Each sample contains 6 tablets and a filled Sucaryl® Sweetener dispenser. For a supply, write Abbott Laboratories or ask your Abbott man.

Desbutal 15 Gradumet

Product of choice for patients who overreact to plain amphetamine

As an anorectic in treatment of obesity, also to counteract anxiety and mild depression. Desbutal is contraindicated in patients taking a monoamine oxidase inhibitor. Nervousness or excessive sedation have occasionally been observed, often these effects will disappear after a few days. Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism or who are sensitive to sympathomimetic drugs. Careful supervision is advisable with maladjusted individuals.

A single Gradumet tablet in the morning provides all-day appetite control.

Desbutal 10 contains 10 mg. of methamphetamine hydrochloride and 60 mg. of pentobarbital sodium. Desbutal 15 contains 15 mg. of methamphetamine hydrochloride and 90 mg. of pentobarbital sodium. In bottles of 100 and 500.

Press out tablets from this side

LOT NO. 784-1331



For:

Directions:

Dr.

Sucaryl® Sweeteners

A proven aid to weight control—

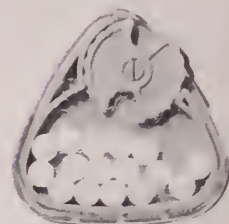
For use in beverages and foods—stable to heat

A constant reminder to your patient to "watch her calories"

A carefully balanced formula to prevent aftertaste

—in tablets and liquid—

Sucaryl—Abbott brand of low and non-caloric sweeteners



economy

Patients, in many cases, save enough to get five weeks of medication for the price of four, compared to other leading long-release anorectics.

CONTRAINDICATION: Desoxyn and Desbutal are contraindicated in patients taking a monoamine oxidase inhibitor.

PRECAUTIONS: Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs or ephedrine and its derivatives. Careful supervision is advisable with maladjusted individuals.



Gradumet—long-release dose form, Abbott: U.S. Pat. No. 2,987,445.
Sucaryl—Abbott brand of low and non-caloric sweeteners.

The Medical Detective



The College Death

During the Easter vacation at a small liberal arts college a student was found in his dormitory room lifeless and trussed up with ropes and a belt. The discovery of his body was made by a janitor who immediately called the town police. They met the local Medical Examiner in the room and their investigation began.

The dean of men was questioned about the student. He was a 17 year old freshman who lived several hundred miles away and who was spending his vacation at the school working on a research project in biology. He was a brilliant student in the upper 10% of his class. He did not appear odd or peculiar; at least he did not appear or act any different than the rest of his classmates. His family were stable people in the middle income bracket.

The room was in fairly good order except for many pictures of nude members of the opposite sex scattered on the floor and the bed. The body was lying on the bed and from the livor mortis it had been in that location since death. The body was unclothed and the arms and legs were tied by a washline. A loop of rope was also tied around

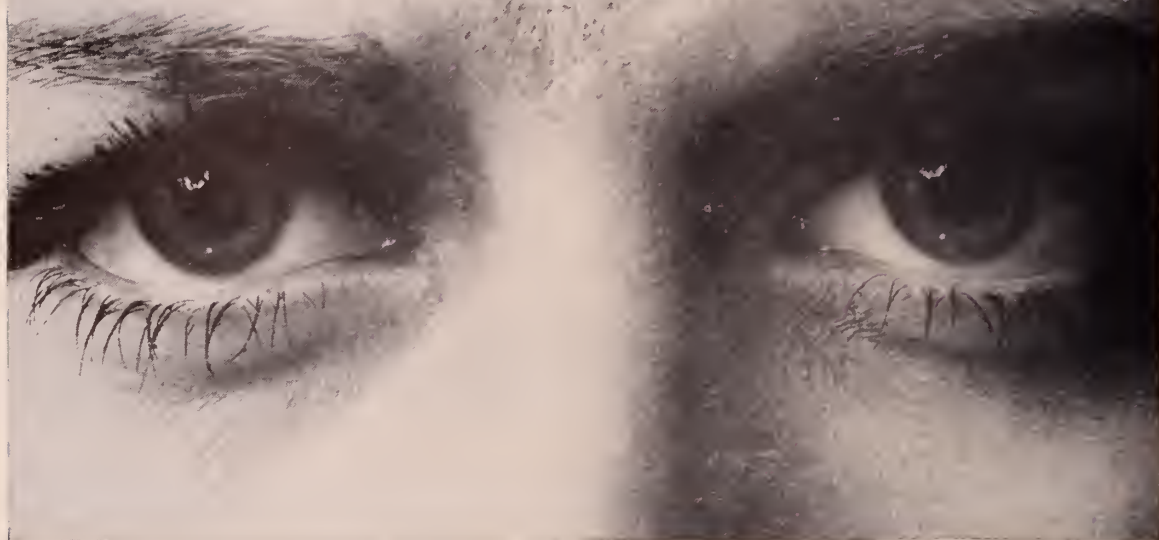
the genitalia and another loop tied to a padded belt around the neck. No signs of injury were seen. Dried ejaculum was noted on the thighs and bed covers. A large mirror was placed in front of his face.

The autopsy revealed that the boy had no natural disease. Death was apparently due to asphyxia secondary to the compression of the airway and or the carotid arteries. The rope was snug on the wrists and the padded belt made a deep imprint on removal. The blood showed a mild alcohol intoxication (0.06 Gm.%—drunk driving 0.15 Gm.%).

Autoerotic strangulation is a recognized entity which has been confused with suicide and homicide by the uninitiated. The explanation of the mechanism of death in these cases is that of accidental compression of the neck during sexual activity or excitement. It has been described in some primitive cultures as a common practice during such activity. Our psychiatrist colleagues would have to be consulted to explain the significance of this behavior.

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rexia, and slight gastric distress. If excessive drowsiness occurs, it may be necessary to increase the interval between doses. Persons on full dosage should not operate any vehicle. Use may result in overgrowth of nonsusceptible organisms. If infections appear during therapy, appropriate measures should be taken. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Infections caused by beta-hemolytic streptococci should be treated for at least 10 full days to help prevent rheumatic fever or acute glomerulonephritis. Use of tetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect has been observed in usual short treatment courses.

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References: 1. Shumon, C.: *Am. J. Med. Sci.*, 225:54, 1953. 2. Perchuk, E., et al.: *Angiology*, 12:102, 1961. 3. Rowls, W., et al.: *Med. Times*, 87:818, 1959.

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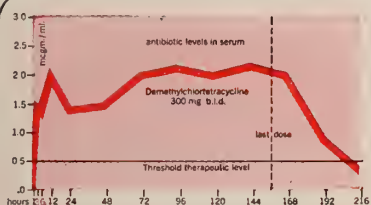
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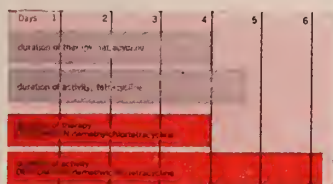
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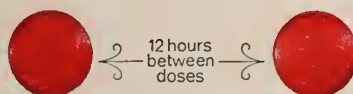
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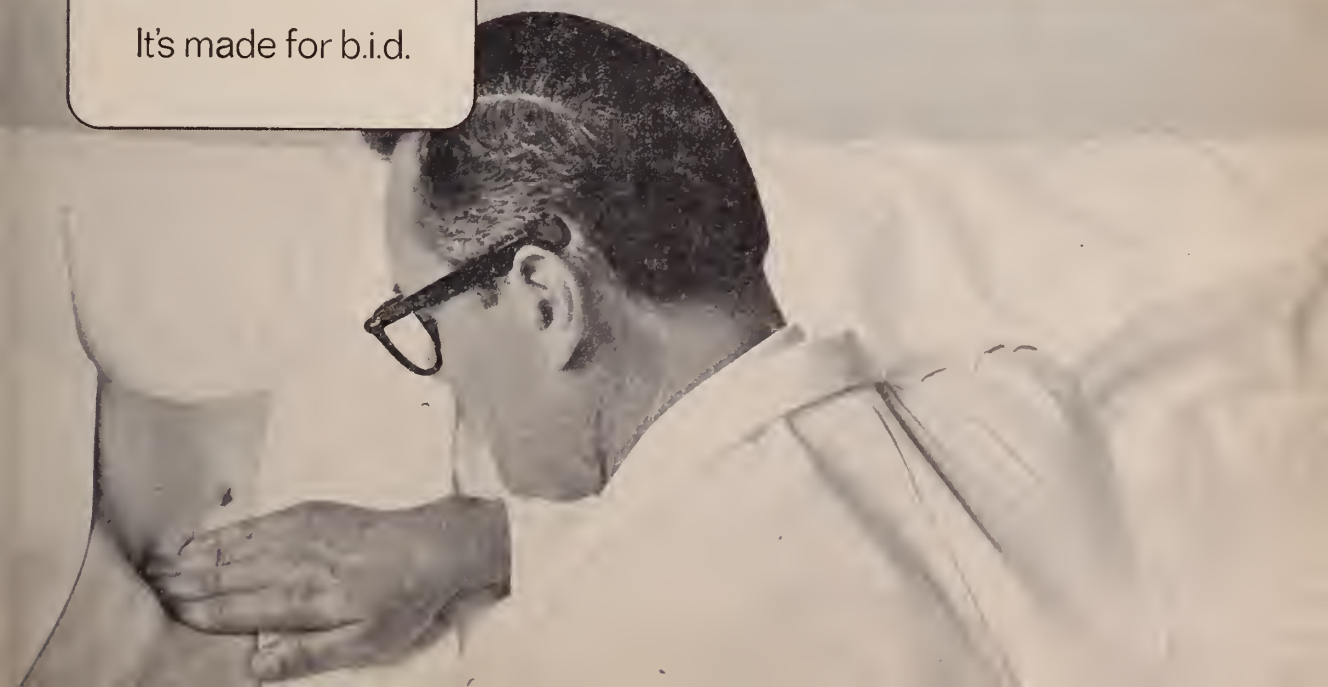
Contraindication—History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort.

Precautions and Side Effects—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

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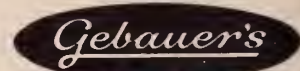
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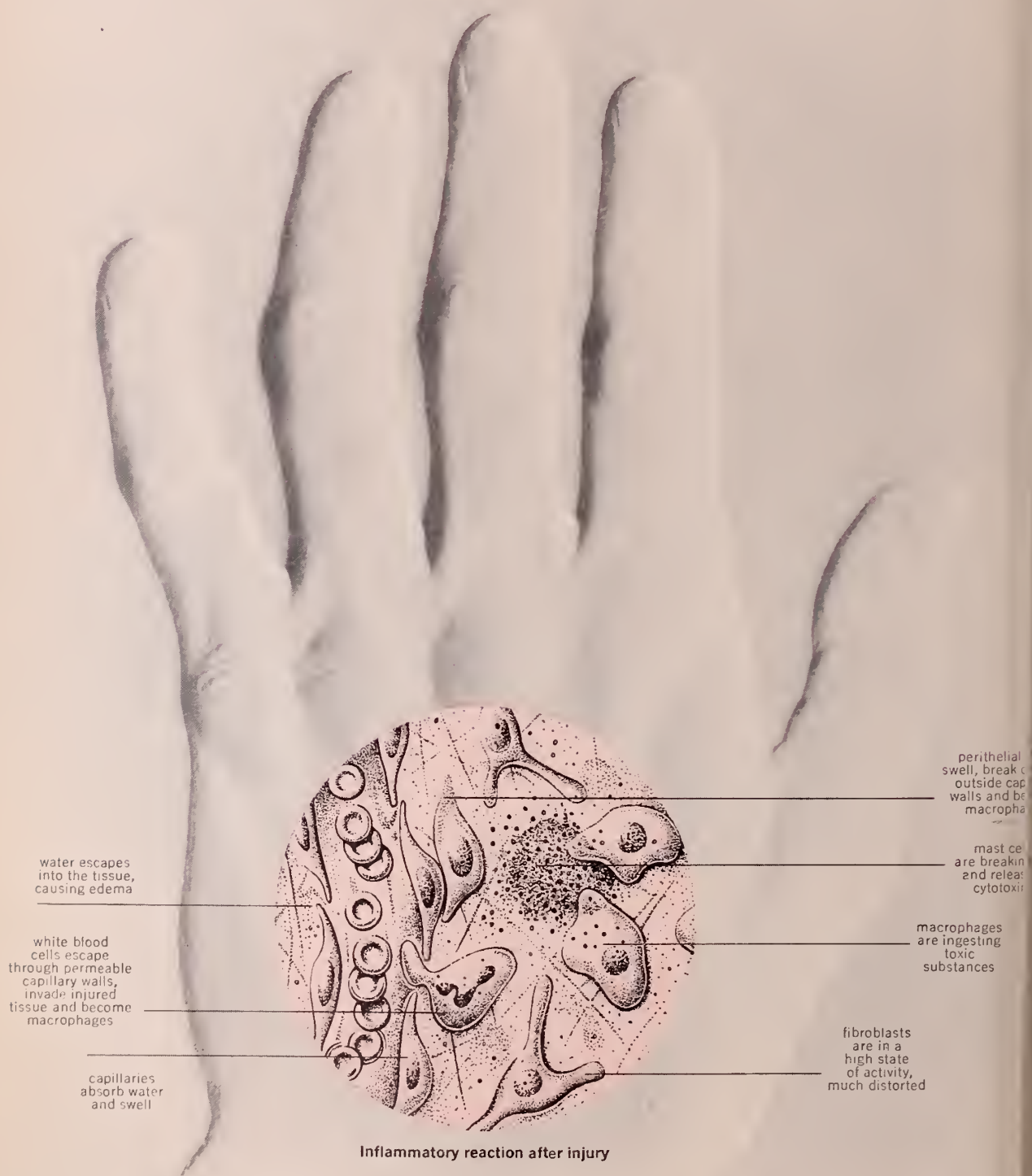
The following is a brief precautionary statement. Before prescribing, the physician should be familiar with the complete prescribing information in SK&F literature or PDR. **Contraindications:** Comatose or greatly depressed states due to C.N.S. depressants and in cases of existing blood dyscrasias, bone marrow depression and liver damage. **Precautions:** Use with caution in angina patients and in patients with impaired cardiovascular systems. Antiemetic effect may mask symptoms of other disorders. An additive depressant effect is possible when used with other C.N.S. depressants. Prolonged administration of high doses may result in accumulative effects with severe C.N.S. or vasomotor symptoms. Use in pregnant patients only when necessary for the patient's welfare. **Side Effects:** Occasional cases of mild drowsiness, dizziness, mild skin reactions, dry mouth, insomnia and amenorrhea. Neuromuscular (extrapyramidal) reactions (motor restlessness, dystonias, pseudo-parkinsonism) may occur and, in rare instances, may persist. In addition, muscular weakness, anorexia, rash, lactation, hypotension, and blurred vision have been observed. Blood dyscrasias and cholestatic jaundice have been extremely rare.

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References: 1. Kanee, B.: Canad Med Ass J 88:999 (May 18) 1963. 2. Scholtz, J. R.: Calif Med 95:224 (Oct.) 1961. 3. Jansen, G. T., Dillaha, C. J., and Honeycutt, W. M.: Arch Derm 92:283 (Sept.) 1965.

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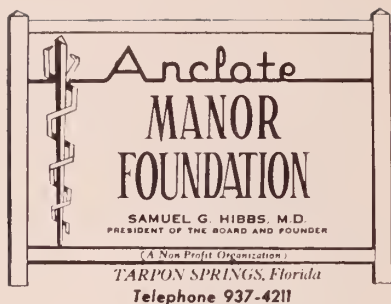
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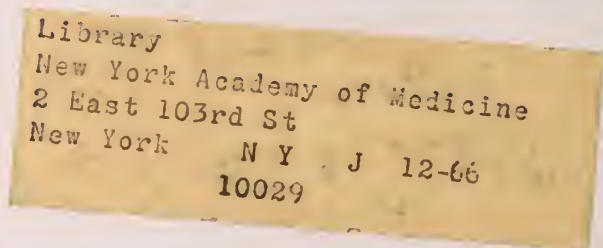
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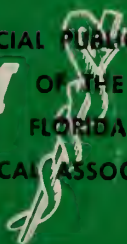
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Wound Suction Drainage
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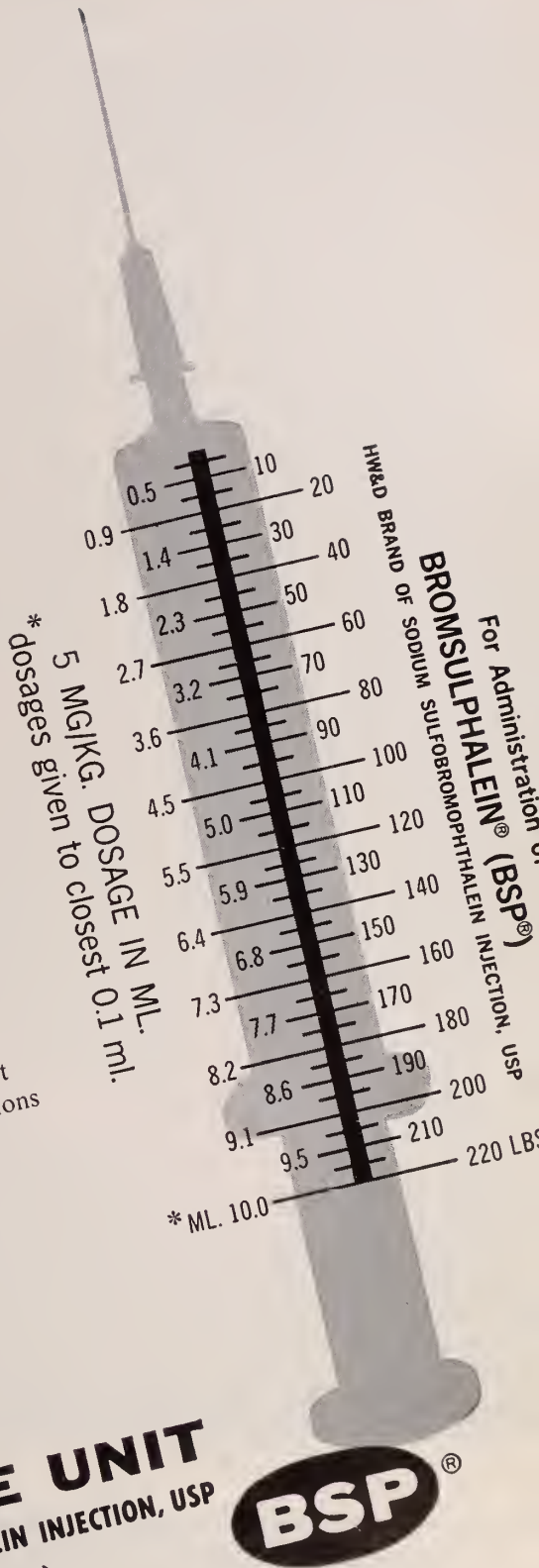
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The JOURNAL

of the Florida Medical Association

Volume 53, Number 10, October 1966

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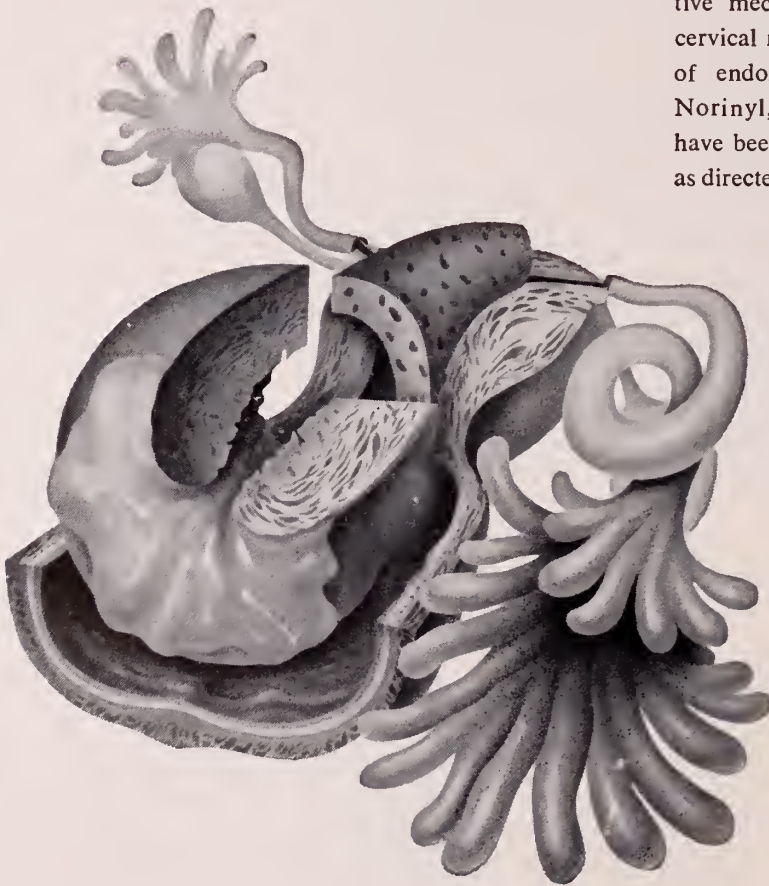
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Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-

ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism. **Side Effects:** Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: 1. Council on Drugs, JAMA 187:664 (Feb 29) 1964. 2. Brians, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. 3. Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. 4. Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. 5. Hammond, D. O.: Ibid. 6. Rice-Wray, E.: Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. 7. Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. 8. Kemper, R. D.: CP 29 88 (Jan.) 1964. 9. Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. 10. Rudel, H. W., Martinez-Manautou, J., and Maqueo-Tapete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. 11. Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association, JAMA 194:462 (Oct. 25) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964. 16. Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

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In *The Pharmacologic Basis of Therapeutics*, Goodman and Gilman affirm, "Iodide salts are useful expectorants when it is desired to liquefy tenacious bronchial secretions, for example, in the later states of bronchitis, bronchiectasis, and asthma." Ed.3, New York, Macmillan, 1965, p.815.

When discussing symptomatic therapy of status asthmaticus, Hildreth recently stated, "There is little evidence that any expectorant other than potassium iodide is of practical value in this situation." Hildreth, E. A., *Postgrad. Med.*, 38:460 (Nov.) 1965.

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new



a new formulation that relieves pain in tension headache and neuralgia

Dialog is a combination of 15 mg allobarbitol and 300 mg acetaminophen. Allobarbitol, a proven barbiturate, provides desirable sedation in patients experiencing pain and discomfort. Acetaminophen is a nonsalicylate analgesic-antipyretic, well tolerated and useful in a wide range of mildly painful and febrile conditions.

Dialog is well tolerated, even by those sensitive to aspirin. It is nonirritating to the gastrointestinal tract and, in recommended dosage, has no adverse effects on the kidneys.

- Raises the pain threshold
- Suppresses the pain-producing mechanism
- Reduces emotional tension

For tension headach

DialogTM (allobarbitol and acetaminophen CIBA)

Indications: For relief of pain and discomfort of simple headache; neuralgia, myalgia, and musculoskeletal pain; dysmenorrhea; bursitis; sinusitis; fibrositis. Also indicated to reduce fever and to relieve discomfort due to respiratory infections, influenza, and other febrile conditions.

Contraindication: Not recommended during pregnancy.

Caution: May be habit-forming. Do not use in patients sensitive to barbiturates or in those with moderate to severe hepatic disease.

Side Effects: Nausea, transitory dizziness, rash. Overdosage of allobarbitol produces symptoms typical of acute barbiturate excess.

Dosage: *Adults:* 1 or 2 tablets every 4 hours. Not to exceed 8 tablets in 24 hours. *Children 6 to 12:* 1/2 to 1 tablet every 4 hours. Not to exceed 4 tablets in 24 hours.

Supplied: *Tablets* (white, scored), each containing 15 mg allobarbitol and 300 mg acetaminophen; units of 3 bottles of 30.

For your convenience—prescription-size bottle of 30.
CIBA Pharmaceutical Company, Summit, N. J.

C I B A

**How long will
it take her
to recover from
her hip fracture
if she just
doesn't care?**



Does she really care?
Is she alert, encouraged,
positive and optimistic
without getting completely
tired soon?
Or has she given in to
a demoralizing impact
of confinement, disability
and dependency?
When functional fatigue
complicates convalescence,
Alertonic can help...

Pleasant-tasting Alertonic is pipradrol hydrochloride—an effective cerebral stimulant whose gentle analeptic action helps counteract the apathy and inertia that can often delay convalescence—together with an excellent vitamin and mineral formula, in a satisfying 15% alcohol vehicle.

Nothing fosters confidence and a sense of well-being better than your own personal warmth, understanding and encouragement together with Alertonic to help insure prompt response.

Adequate dosage is important: Prescribe Alertonic—one tablespoonful t.i.d., 30 minutes before meals...tastes best chilled.

And for your patient's sake, prescribe Alertonic in the convenient, economical one-pint bottle.

Alertonic[®]

Available Only On Prescription

Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%; pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin B₁) (10 MDR*), 10 mg.; riboflavin (vitamin B₂) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin B₆), 1 mg.; niacinamide (5 MDR), 50 mg.; choline,[†] 100 mg.; inositol,[†] 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.

[†]The need for these substances in human nutrition has not been established.

Indications: 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

Contraindications: As with other drugs with CNS stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive compulsive states.

Side effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Merrell

THE WM. S. MERRELL COMPANY
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215

**When
thiazide
or
reserpine
alone
won't
keep**

**BLOOD
PRESSURE
SURE
DOWN**

Establish and maintain early, more decisive control of blood pressure

DIUTENSEN-R®

Cryptenamine 1.0 mg.* Methyclothiazide 2.5 mg. Reserpine 0.1 mg.

When blood pressure won't stay down despite initial therapy — when complaints of headache, fatigue or dizziness are often voiced — it may be time for a change to DIUTENSEN-R.

DIUTENSEN-R is thiazide and reserpine *plus* cryptenamine — a rational, comprehensive therapy to help establish and maintain early, more decisive control of blood pressure.

The cryptenamine in DIUTENSEN-R helps improve normal vasodilating reflexes while the thiazide and reserpine components maintain vasorelaxant, sedative, and saluretic benefits. Cryptenamine lowers pressoreceptor reflex thresholds (which may be abnormally high in hypertension) — “resets” pressoreceptors to function at more nearly normotensive levels.

Early, more decisive control with DIUTENSEN-R helps secure continuing benefits — may reduce or even obviate the need for poorly tolerated drugs later in therapy.

“...quite apart from the problem of vascular damage, there arises a possibility of virtual ‘cure’ or remission of hypertension when treatment is early, i.e., before too many other secondary pressor systems have entered into the disequilibrium of pressor control, and when it is adequately suppressive.”

Corcoran, A. C.: The choice of drugs in the treatment of hypertension. In: *Drugs of Choice* 1966-67, W. Modell, Ed., St. Louis, C. V. Mosby Company, 1966, p. 417.

Indications: DIUTENSEN-R may be employed in all grades of essential hypertension.

Dosages: Usual dose is 1 tablet twice daily, at morning and evening meals.

However, adjustment of dosage to suit individual circumstances may be required. Please refer to package insert for full particulars. **Side effects and**

precautions: The side effects observed with patients on DIUTENSEN-R have been of a mild and nonlimiting nature. These include occasional urinary frequency, nocturia, nasal congestion, muscle cramps, skin rash, joint pains due to gout symptoms and nausea and dizziness which have been reported for the individual components. Most of these symptoms disappear while the drug is continued at the same or lower dosage level. The concomitant use of digitalis and DIUTENSEN-R may increase the possibility of digitalis-like intoxication. If there is evidence of myocardial irritability (extrasystoles, bigeminy or AV block), dosage of DIUTENSEN-R should be reduced or discontinued. Nocturia in patients with marginal cardiac status and salt and fluid retention can be effectively controlled by limiting the time of administration to early afternoon.

DIUTENSEN-R should not be used in patients with a known intolerance to reserpine.

Package inserts furnish a complete summary of recommended cautions related to each of the ingredients of DIUTENSEN-R.

*As tannate salts equivalent to 130 Carotid Sinus Reflex Units.

NEISLER



NEISLER LABORATORIES, INC. • DECATUR, ILLINOIS
SUBSIDIARY OF UNION CARBIDE CORPORATION



Breast-feeding and the “modern mother”

Despite a mild resurgence of interest in the importance of breast-feeding a few years ago, many women today do not choose to nurse their young. This is for a variety of reasons—social, economic, cultural and sometimes medical. In such cases the physician's task is to find the most suitable means of preventing lactation and easing the pain of breast engorgement.

The means of therapy

The value of hormone therapy for this indication is of course well established. Both androgen and estrogen are known to inhibit the production and secretion of the lactogenic hormone by the anterior pituitary. As estrogen levels decline sharply at parturition, lactogenesis is established. When androgen and estrogen are administered to the patient before the release of the lactogenic hormone lactation and breast engorgement are usually prevented.

The time of therapy

The time of administration of this combined medication is crucial; it must be given early enough to suppress the pituitary prolactin and last long enough to permit physiologic readjustment during the puerperium. Excellent results are most often seen when therapy is administered before the onset of the second stage of labor.

However, factors other than effectiveness must also be considered. The agent selected should not interfere in any way with parturition, subsequent uterine involution and the restoration of normal ovarian cyclic function. Furthermore, it should not cause rebound breast engorgement or other manifestations of hormonal imbalance.

A balanced formulation

Providing single-dose therapy for the prevention of lactation and breast engorgement, Deladumone OB is a potent androgen-estrogen combination with a prolonged action. The optimal balance of androgenic and estrogenic hormones achieved in this preparation minimizes the disadvantages inherent in single hormone therapy, such as rebound breast engorgement. Involution of the uterus and resumption of menstrual cycles are not affected.

As reported in a recent published study (Roser, D. M.: *Obstet. & Gynec.* 27:73, 1966), Deladumone OB provided good suppression of breast engorgement in 95.3% and suppression of lactation in 81.1% of 86 obstetrical patients. These results are in general agreement with those of many earlier investigations; in several studies this injectable androgen-estrogen combination proved to be superior to oral medication.

Dosage:

As a single injection of 2 cc. before the onset of the second stage of labor.

Contraindications:

Established or suspected mammary cancer or genital malignancy.

Precautions and Side Effects:

Certain patients may be unusually responsive to either estrogenic or androgenic therapy. In such individuals virilization, uterine bleeding or mastodynia may occur.


Supply:

Deladumone OB, providing 180 mg. testosterone enanthate and 8 mg. estradiol valerate per cc., is available in 2 cc. Unimatic® disposable syringes and in 2 cc. vials. Both preparations are dissolved in sesame oil, with 2% benzyl alcohol as a preservative. *Before use, consult product literature for full prescribing information.*

Deladumone® OB

Squibb Testosterone Enanthate (180 mg./cc.) and Estradiol Valerate (8 mg./cc.)

Single-dose injection for lactation inhibition

SQUIBB  *"The Priceless Ingredient" of every product is the honor and integrity of its maker.*

what time is it?

For the past
two years
there's been
one new case
of active tuberculosis
reported for every
four thousand
of U.S. population.

it's time to time.

Tuberculin, Tine Test

(Rosenthal)

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Available in 5's and 25's.

Order now
from your pharmacist
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representative.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York



414-G-4010R



Diagnosis:

cystitis?
pyelonephritis?
pyelitis?
urethritis?
prostatitis?
 in any case,
 usually gram-negative*

Therapy:

two 500 mg. Caplets® q.i.
 (initial adult dose)

Indications: Urinary tract infections caused by gram-negative and some gram-positive organisms.

Side effects: Mainly mild, transient gastrointestinal disturbances; in occasional instances, drowsiness, fatigue, pruritus, rash, urticaria, mild eosinophilia, reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), and reversible photosensitivity reactions. Marked overdosage, coupled with certain predisposing factors, has produced brief convulsions in a few patients.

Precautions: As with all new drugs, blood and liver function tests are advisable during prolonged treatment. Pending further experience, like most chemotherapeutic agents, this drug should not be given in the first trimester of pregnancy. It must be used cautiously in patients with liver disease or severe impairment of kidney function. Because photosensitivity reactions have occurred in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Bacterial resistance may develop.

When testing the urine for glucose in patients receiving NegGram, Clinistix® Reagent Strips or Tes-Tape® should be used since other reagents give a false-positive reaction.

Dosage: Adults: Four Gm. daily by mouth (2 Caplets® of 500 mg. four times daily) for one to two weeks. Thereafter, if prolonged treatment is indicated, the dosage may be reduced to two Gm. daily. Children may be given approximately 25 mg. per pound of body weight per day, administered in divided doses. The dosage recommended above for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Until further experience is gained, infants under 1 month should not be treated with the drug.

How supplied: Buff-colored, scored Caplets® of 500 mg. for adults, conveniently available in bottles of 56 (sufficient for one full week of therapy) and in bottles of 1000. 250 mg. for children, available in bottles of 56 and 1000.

References: (1) Based on 23 clinical papers, 1512 cases. Bibliography on request. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: Antimicrobial Agents and Chemotherapy — 1964, Ann Arbor, American Society for Microbiology, 1965, p. 722.

NegGram
 Brand of
nalidixic acid
 a specific anti-gram-negative

**eradicates most urinary
 tract infections...**

- Low incidence of untoward effects; no fungal overgrowth, crystalluria, ototoxic or nephrotoxic effects have been observed.
- "Excellent" or "good" response reported in more than 2 out of 3 patients with either chronic or acute gram-negative infections.¹

*As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms: E. coli, Klebsiella, Aerobacter, Proteus, Paracolon or Pseudomonas²... However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.

Winthrop

Winthrop Laboratories, New York, N. Y. 10016

DORSEY

fall 1966

Season

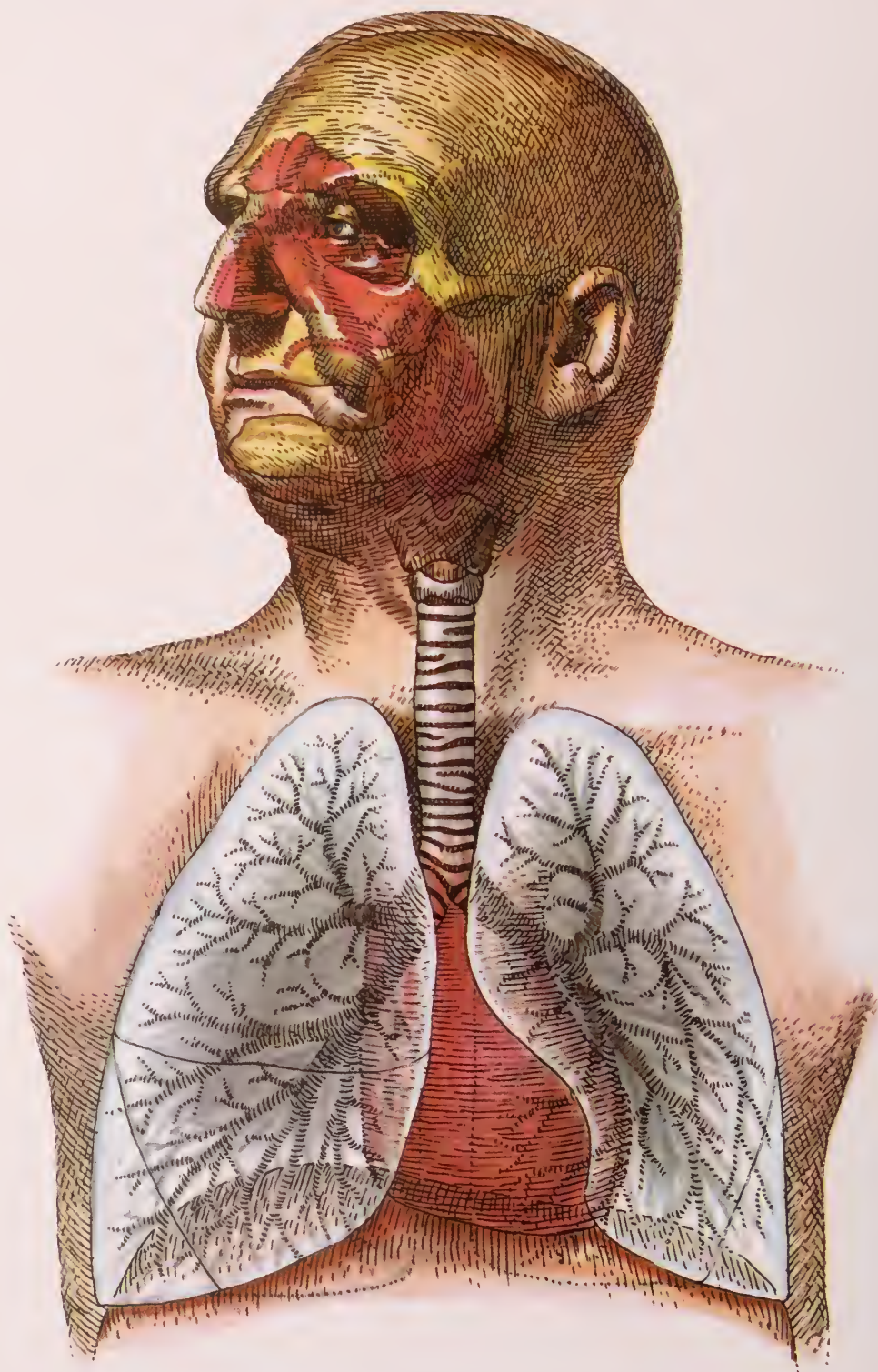
A journal within a journal published quarterly in the interests of better medicine by Dorsey Laboratories, a division of The Wander Company, Lincoln, Nebraska. Address communications to Raymond C. Pogge, M.D., Director of Medicine.



this issue: the common cold and the aging patient

the common cold and the aging patient

Louis J. Vorhaus, II, M.D., F.A.C.P.



G. SCHWENK

Effects of aging on the anatomic and physiologic aspects of the respiratory apparatus.

The chest becomes more fixed, less mobile and less elastic as the bronchial walls and thoracic ligaments lose elasticity. The diaphragm and intercostal muscles atrophy and weaken. The lungs become smaller, flabbier and weigh less, decreasing vital and total lung capacity, increasing residual volume and the alveolar dead space.

Sir William Osler described pneumonia as the welcome friend of the aged patient, because the patient with pneumonia usually died quietly. But today, the well-informed physician is an even better friend of the aging patient, since it is better to live than to die, no matter how quietly.

One of the first avenues of approach in the control of the hazards of respiratory disease in the aging patient is prompt and proper attention to the common cold or upper respiratory infection. The common cold may be the first step in the relatively short path to lower respiratory infection, broncho-pneumonia and death. This train of events occurs frequently among older persons. Indeed, pneumonia is one of the most common causes of their admission to hospitals and ranks high on the list of geriatric killers. Colds are more debilitating in elderly people and the aged are more likely candidates for secondary infections such as sinusitis and bronchitis. These infections, in turn, are more prone to lead to broncho-pneumonia, because of lowered resistance and anatomic and physiologic changes in the lungs of the elderly.

What is different about the respiratory tree of an aged person and that of an otherwise healthy younger adult? Aging certainly takes its toll on all parts of the body, affecting both anatomic and physiologic aspects of the respiratory apparatus. These changes are in part due to the wear and tear that occurs over the years; the repeated bouts of respiratory infection, long exposure to atmospheric pollutants, to occupational inhalants, smoking, malnutrition, obesity, inactivity and the development of other diseases which may affect the lungs.

With the passage of years, the lungs change. They become scarred and emphysematous and lose their compliance. The whole chest becomes more fixed, less mobile and less elastic.

the anatomic changes that occur in aging render the lungs less efficient. Tests of pulmonary function in senescence show a deterioration characterized by a decrease in vital capacity and total lung capacity, an increase in residual volume and alveolar dead space. Maximum breathing capacity is reduced and uniformity of ventilation deteriorates. These problems are often aggravated by the obstructed breathing, fever and secondary infection associated with the common cold, placing an additional stress on the entire cardiopulmonary reserve.

In addition, the efficiency of a cough is below par in older persons even though they are in good health. This is partly due to the decreased respiratory excursions and distensibility of the chest wall, and partly from loss of elasticity of bronchial walls which tend to make them collapse in a cough.

The elderly patient's resistance to infection is often reduced. Nutritional deficiencies are more common in aged people. There is some evidence to indicate that their capacity to respond to stress is less efficient. Finally, there is often relatively meager symptomatic response to acute disease. The absence of obvious or dramatic clinical signs and symptoms of severe illness is particularly dangerous because, coming as it

(concluded on following page)

it's a comforting thing to know



For postnasal drip, clogged ears

and stuffed and runny noses

Triaminic® timed-release tablets

keeps patients comfortable 'round the clock. 24-hour decongestion on just a single tablet dosed morning, mid-afternoon and at bedtime. Patients regain senses and can breathe, smell and taste again.

Triaminic. Isn't that a comforting thing to know?

Each timed-release tablet contains:

Phenylpropanolamine hydrochloride	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. **Precautions:** The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

(Advertisement)

does in a person whose defenses are weakened both locally and systemically, pulmonary disease may progress rapidly to irreversible stages before medical attention is sought. Respiratory infection is especially hazardous because the aged patient responds badly to hypoxia. Not only is his response to oxygen lack impaired, but the work of breathing, due to decreased compliance of the lung and increased stiffness of the thorax, is markedly augmented. Many patients late in life are in a precarious and delicate cardiopulmonary balance which is easily decompensated from relatively minor insults such as colds and upper respiratory infections.

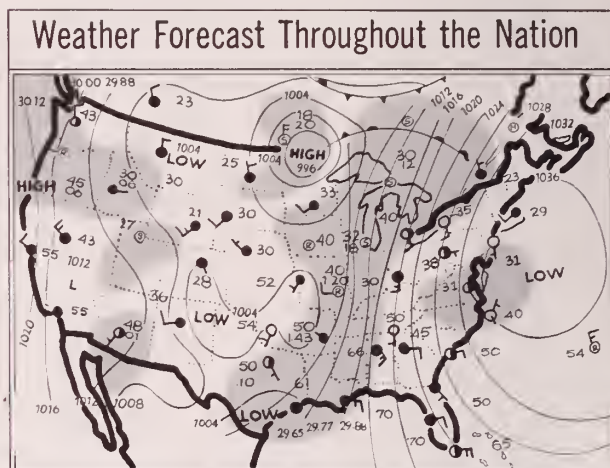
For all of these reasons, geriatricians long have stressed the importance of preventing respiratory insults. Today we have better ways of treating respiratory infection, improved techniques for clearing the lungs and bronchial tubes of secretions and better understanding of ways of improving ventilation. We possess a broader spectrum of antimicrobial agents including newer ones to deal with previously resistant organisms. Even so, the death rate from pneumonia is high in older people, and it is preferable to avoid the disease than to treat it. To do so, attention must be paid to the general maintenance of good health and all that implies, as well as to the prevention, elimination and treatment of associated conditions that predispose to or cause pneumonia such as chronic upper or lower respiratory infection, respiratory allergy, chronic sinusitis and exposure to inspired irritants.

Colds and other minor respiratory infections, which favor the development of broncho-pneumonia, should be treated vigorously and promptly, particularly those patients whose aging process has been accompanied by the development of chronic pulmonary disease. Upper respiratory passages should be cleared with decongestants. Sinuses should be drained adequately. And, when indicated, appropriate antimicrobial therapy should be instituted before serious infection of the lower respiratory tree supervenes.

In decades past it was understandable that physicians welcomed pneumonia for the aged patients because it offered them a quiet and peaceful demise. Today we recognize that in many cases, peaceful as it may have been, such deaths were often avoidable. With the current knowledge and understanding of the problems that respiratory infections impose on aging people, vigilant medical attention can often

restore them to a vigorous, rewarding and productive life so that the many opportunities that exist today for people to enjoy their golden years are realized and not stolen by untimely death.

- References**
1. Steigltz, Edward J., *Geriatric Medicine, Medical Care of Later Maturity*, 3rd edition, J. B. Lippincott Co., Philadelphia, 1954.
 2. Norman, J. R., Schweppe, I. H., Salazar, E., and Knowles, J. H., Lung Volumes and Aging, *Journal of the American Geriatrics Society*, 12, pp. 38-47, January 1964.
 3. Penman, Robert W. B., Hypoxia and Respiratory Failure, *Geriatrics*, 18, 807-814, November 1963.
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 6. Horton, Glenn, Testing of Pulmonary Function, *Geriatrics*, 17:73-81, February 1962.
 7. Banyai, Andrew L., Cough and its Management in Elderly Patients, *Geriatrics*, 14:621-630, October 1959.
 8. Howell, T. H. and Piggot, A. P., Morbid Anatomy of Old Age, *Geriatrics*, 8:267-72, March 1953.



RAIN TURNING TO SNOW, INCREASING WINDS AND DROPPING TEMPERATURES FOLLOWED BY COUGH, CONGESTION AND PAIN

Tussagesic® provides up to 24-hour coverage of the tough cold with a single timed-release tablet dosed morning, midafternoon and at bedtime. Coughs are broken up, runny and stuffed noses are cleared and pain is relieved.

Each Tussagesic® timed-release tablet contains:

Triaminic®	50 mg.
(phenylpropanolamine hydrochloride 25 mg.; pheniramine maleate 12.5 mg.; pyrilamine maleate 12.5 mg.)	
Dextromethorphan hydrobromide	30 mg.
Terpin hydrate	180 mg.
Acetaminophen	325 mg.

Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. **Precautions:** Patient should not drive a car or operate dangerous machinery if drowsiness occurs. Except under professional care, do not give to patients under 12 yrs. or those who have persistent cough, high fever, heart or thyroid disease, hypertension or diabetes or use for more than 10 days.

when congestion is complicated by sulfa-susceptible
bacterial invaders in the
upper respiratory tract...



re-enforce your decongestant therapy

prescribe economical **Trisulfaminic[®]**

Each tablet contains: Triaminic[®] 25 mg. (phenylpropanolamine hydrochloride 12.5 mg., pheniramine maleate 6.25 mg., pyrilamine maleate 6.25 mg.); Trisulfapyrimidines, U.S.P. 0.5 Gm. (sulfadiazine 0.167 Gm., sulfamerazine 0.167 Gm., sulfamethazine 0.167 Gm.)

PHARMACOLOGY: Triaminic decongests and promotes drainage of nasal and paranasal passages, and prevents any further histamine-induced damage; the triple sulfonamides inhibit susceptible bacterial invaders. **INDICATIONS:** For congestion and infection of the upper respiratory tract caused by sulfa-susceptible organisms. **DOSAGE:** Adults: 2 to 4 tablets initially, followed by 2 tablets every 6 hours. Medication should be continued until patient has been afebrile for 3 days. **ADVANTAGES:** The advantages of Trisulfaminic in upper respiratory infections are: freedom from narcotics or alcohol; therapeutic reliability; safety; economy; ease of administration; freedom from potential sensitization to broad-spectrum antibiotics which may be reserved for lower respiratory or other infections caused by susceptible organisms. **CONTRAINDICATIONS:** Contraindicated in sulfonamide and antihistamine sensitivity, impaired renal function, pregnancy approaching term, and in premature infants and newborn infants during the first month of life. Do not use in patients with glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction.

WARNING: Use only after careful evaluation in patients with liver or renal damage, urinary obstruction, or blood dyscrasias. Deaths have been reported from hypersensitivity reactions with administration of sulfonamides. In intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed periodically. Sulfonamide therapy may potentiate the hypoglycemic action of sulfonylureas. **PRECAUTIONS:** Use with caution in patients with histories of significant allergy or asthma. Assure an adequate fluid intake. Because the antihistamines may cause drowsiness of varying degree, warn patients about activities requiring alertness such as driving a car or operating dangerous machinery. Use with caution in the presence of hypertension, hyperthyroidism, cardiovascular disease and diabetes. **ADVERSE REACTIONS:** As in all sulfonamide therapy, the following reactions may occur: headache, nausea, vomiting, diarrhea, icterus, hepatitis, pancreatitis, urticaria, rash, fever, cyanosis, hematuria, crystalluria, proteinuria, blood dyscrasias, petechiae, purpura, neuropathy and injection of the conjunctiva and sclera. If

one or more of these reactions occur, the drug should be discontinued. With antihistaminic therapy there have been reports of sedation varying from mild drowsiness to deep sleep, dizziness, lassitude, inability to concentrate, fatigue, incoordination, tininitus, blurred vision, diplopia, euphoria, nervousness, insomnia, tremors, palpitation, hypotension, headache, chest tightness, urinary frequency, dysuria, tingling of the hands, dryness of the mouth, throat, and nose, gastrointestinal disturbances such as epigastric distress, anorexia, nausea, vomiting, constipation and diarrhea and very rarely, leukopenia and agranulocytosis. Adverse reactions reported with the use of sympathomimetic amines include anxiety, tension, restlessness, nervousness, tremor, weakness, insomnia, headache, palpitation, tachycardia, angina, elevation of blood pressure, sweating, mydriasis, anorexia, nausea, vomiting, dizziness, constipation, and dysuria due to vesicle sphincter spasm. **PACKAGE INFORMATION:** Trisulfaminic Tablets: Supplied in bottles of 100 tablets. **CAUTION:** Federal law prohibits dispensing without prescription.

DORSEY LABORATORIES • a division of *The Wander Company* • **LINCOLN, NEBRASKA**

When uncontrolled diarrhea brings a call for help



When the diarrhea sufferer has run the gamut of home remedies without success, pleasant-tasting CREMOMYCIN can answer the call for help. It can be counted on to consolidate fluid stools, soothe intestinal inflammation, inhibit enteric pathogens, detoxify putrefactive materials — usually within a few hours.

CREMOMYCIN combines the bacteriostatic agents succinylsulfathiazole and neomycin, with the adsorbent and protective demulcents, kaolin and pectin, for comprehensive control of diarrhea.

INDICATIONS: Diarrhea.

CONTRAINDICATIONS: Do not use in intestinal obstructive disease, extensive ulceration of bowel, or diverticulosis; in hypersensitivity to sulfonamides or neomycin; in pregnancy at term, in premature infants, or during first week of life in the newborn.

WARNINGS: Use only after critical appraisal in patients with hepatic or renal damage, urinary obstruction, or blood dyscrasias. Fatal hypersensitivity reactions and blood dyscrasias reported with use of sulfonamides. Consider periodic blood counts and hepatic and renal function tests during intermittent or chronic use.

PRECAUTIONS: *Succinylsulfathiazole:* Use with caution if there is history of significant allergies and/or asthma. Continued use requires supplementary vitamins B₁ and K. *Neomycin:* Watch for

your R_x for
Cremomycin
can provide relief



are-like neuromuscular block during anesthesia if neomycin
used preoperatively in large doses when renal function is
or; watch for overgrowth of nonsusceptible organisms. Con-
sider possibility of ototoxicity and nephrotoxicity with prolonged
high dosage.

EFFECTS: As with all sulfonamides: Headache, malaise, an-
emia, G.I. symptoms, hepatitis, pancreatitis, blood dyscrasias,
neuropathy, drug fever, rash, conjunctival and scleral injection,
leukopenia, purpura, hematuria, and crystalluria have been noted.
Reduced fecal output of thiamine and decreased synthesis of
vitamin K have been reported. *Neomycin:* Nausea, loose stools.

Before prescribing or administering, read package circular with
product or available on request.

romptly relieves diarrheal distress

Cremomycin[®]

ANTIDIARRHEAL

Composition: Each 30 cc. contains neomycin sulfate 300 mg.
(equivalent to 210 mg. of neomycin base), succinylsulfathiazole
100 mg., colloidal kaolin 3.0 Gm., pectin 0.27 Gm.

MERCK SHARP & DOHME Division of Merck & Co., Inc., West Point, Pa.

here today's theory is tomorrow's therapy

only one in the morning 

and one in the evening 

Now b.i.d. convenience plus even greater patient savings over q.i.d. tetracycline therapy

(plus all the advantages of
tetracycline phosphate complex)

new Tetrex bid CAPSTM*

(tetracycline phosphate complex)

Maximum patient savings. New bidCAPS now enable you to prescribe tetracycline in an even more economical, more convenient form. Your patient's prescription dollar gets maximum value: a daily bidCAPS dose is priced lower than any other leading brand of tetracycline—b.i.d. or q.i.d.

Well tolerated. Tetrex (tetracycline phosphate complex) is well tolerated. Gastrointestinal side effects are few; photodynamic reactions are extremely rare.

More of the active antibiotic in the blood. The basic tetracycline in Tetrex (tetracycline phosphate complex) is less bound to serum protein than is demethylchlortetracycline.¹ Result: Tetrex (tetracycline phosphate complex) provides a higher percentage of active antibiotic in the blood.

Available in bottles of 16 and 50.

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York

BRISTOL THERAPEUTIC SUMMARY: For complete information consult Official Package Circular. **Indications:** Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms. **Contraindications:** The drug is contraindicated in individuals hypersensitive to tetracycline. **Warnings:** Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). **Precautions:** Mycotic or bacterial superinfection may occur. Infants may develop increased intracranial pressure with bulging fontanelles. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. **Adverse Reactions:** Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis and allergic reactions may occur. **Usual Adult Dose:** 500 mg. b.i.d. Continue therapy for 10 days in beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals.

Reference: 1. Roberts, C. E., Jr.; Perry, D. M.; Kuharic, H. A., and Kirby, W. M. M. A. M. A. Arch. Int. Med 107:204 (Feb.) 1961.

*bidCAP contains: Tetrex (tetracycline phosphate complex equivalent to 500 mg. tetracycline HCl activity).





Herbert! It's good to see you get away from the office.

reminds me. Remember those sinus pills I've been taking?

What you can do for the patient out here is let him get through. But when he comes again Monday morning, I usually give him the same old looking for with Novahistine.

The tablet provides prompt relief for relief of pain. Then Novahistine also attacks the underlying cause of the headache—helps open blocked respiratory

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Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution your ambulatory patients that Novahistine may occasionally cause

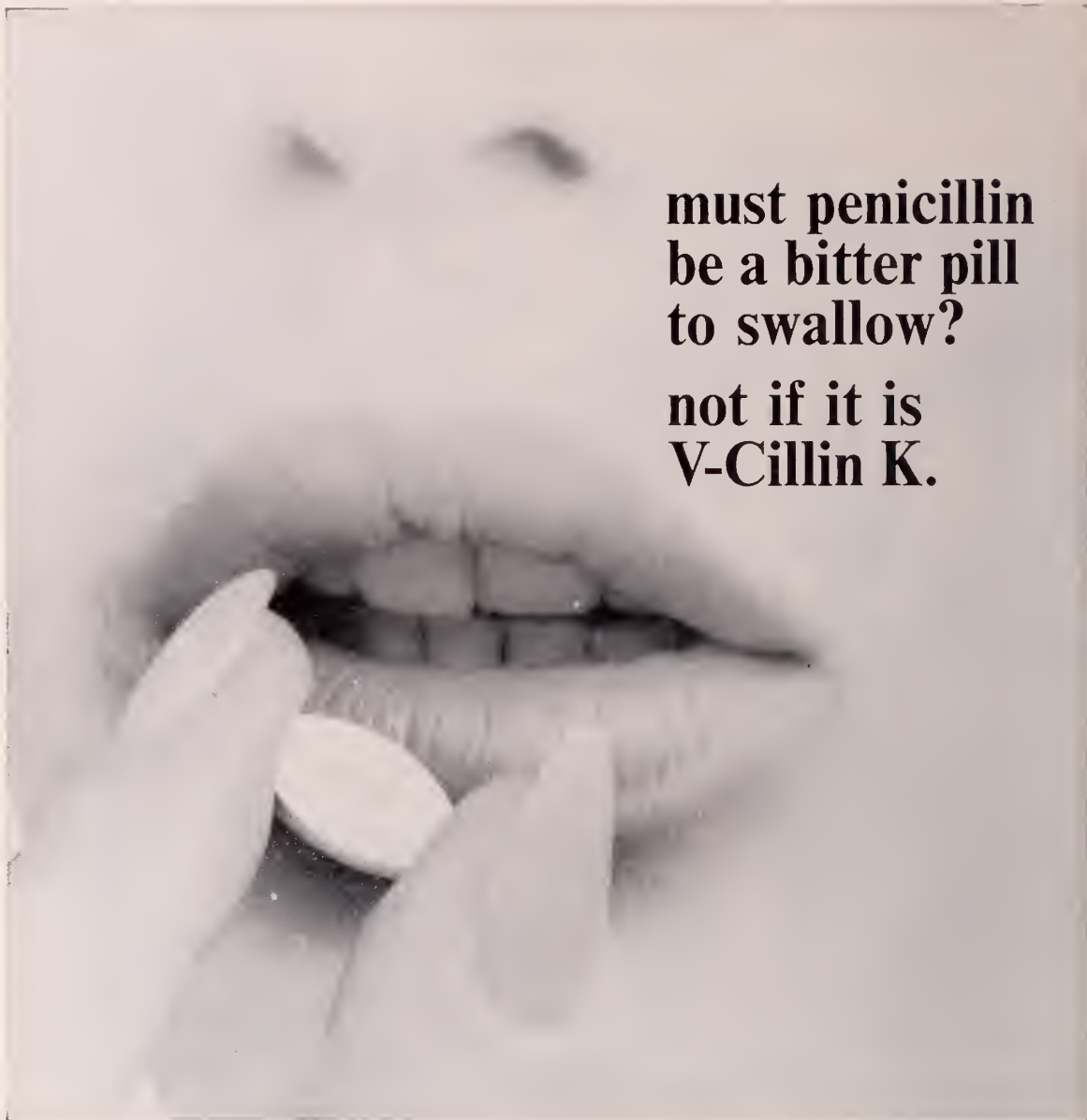
drowsiness. Each tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.

NOVAHISTINE[®]
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For relief of sinusitis pain and congestion.



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Supplied: Tablets V-Cillin K, 125 or 250 mg., and V-Cillin K, Pediatric, 125 mg. per 5-cc. teaspoonful, in 40, 80, and 150-cc.-size packages.

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Barrier to
Bitterness
**Potassium Phenoxymethyl
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The JOURNAL
of the Florida Medical Association

Gratification Accomplished Inadvertently

Editor's Note: This issue of the Journal will be the fifth of its type to be devoted largely to scientific presentations and editorials by the members of a single county medical society. In furnishing the material this month, the Bay County Medical Society joins its predecessors in these unique efforts: Brevard, Marion, Broward and Escambia.

We would like to congratulate each of the physicians who contributed to this issue. In particular we want to thank our Association's Past President, Dr. William C. Roberts of Panama City, who very graciously and competently carried out the often thankless task of serving as guest editor. We are sure he joins with us in offering this fine issue as a challenge to other county medical societies to share their scientific interests and editorial thoughts with the entire Florida Medical Association membership.

T.M.

The Editor of the Journal of the Florida Medical Association approached me concerning the possibility of the Bay County Medical Society sponsoring an issue for The Journal sometime in the not too distant future. This was indeed a real compliment and would in my opinion be a great privilege. The matter would, however, have to be considered by the society. The invitation and the challenge were presented to the society. The members quickly accepted unanimously the opportunity and seemingly with much enthusiasm. They also elected me the Guest Editor for this undertaking.

Immediately I asked for volunteers for contributions, either scientific or editorial. It was thought that all the members would grasp this opportunity to contribute. I received three outright volunteers at this time. Later, after seeking out members whom I could count on to write articles, I received enough promises to satisfy the issue. Some of these promises were lived up to

while others failed for one reason or another. Finally, after much urging and prodding, several fine scientific and editorial contributions came forth, but much later than was desired. The task having been consummated, I am certain each member who contributed was filled with gratification for himself as well as for the society. We hope the staff of the Journal will accept our offering and those members of the Association who read this issue will enjoy and get something from our efforts.

To contribute a paper or an editorial to a journal is no mean task. Everyone who has done so will admit this fact. It would be great if more members would take the time and make the effort to put their talents, skills and thoughts on paper and offer their contributions to our Journal, whereby interesting and worthwhile scientific information as well as other thoughts and opinions can be shared. Often someone in our Association has an interesting and unusual case or a thought that others should know about. Put these on paper and let the Journal have the refusal or acceptance of such offering. It is no disgrace to have your contribution turned down for publication. It is indeed most gratifying when it is accepted. Yes, inadvertently so.

WILLIAM C. ROBERTS, M.D.
PANAMA CITY

Wound Suction Drainage With Silastic Tubing

JOSEPH H. MORRIS, M.D.

The major cause of delayed wound healing is separation of the wound surfaces mechanically by some "foreign material." All wounds contain this material in the form of necrotic tissue that may simply be the ligated blood vessels distal to the ligature, or the ligature itself, and a liquid material which is at first blood that clots, and later a bloody serum. The liquid material is by far the most abundant and it is the most essential component for the growth of bacteria. The blood and serum constitute the major portion of the wound pabulum, and this liquid material that separates the wound margins affords an ideal culture medium for bacteria. Bacteria require a wet surface to grow on and this blood and serum constitute a true "bacteria food."

Silastic tubing* has been used to decompress surgical wounds, both surgical incisions and traumatic wounds. Advantages of Silastic are: (1) it is inert to the tissue; (2) blood clots slowly in it so that it will not plug easily; and (3) it bends gradually rather than kinking so that it rarely becomes obstructed by kinking unless it is bent too acutely.

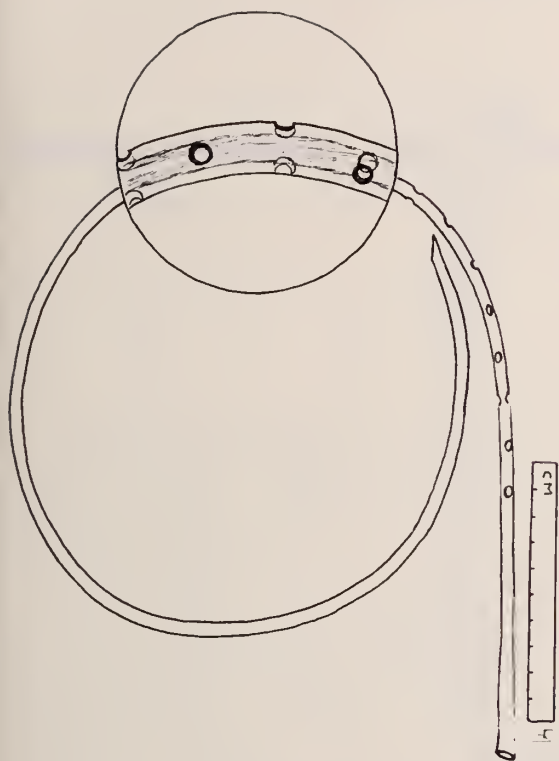
Technique

The tube employed is a single lumen tube with both ends of the tube out of the wound and the holes beneath the flaps. To one end of the tube is applied constant suction and the other end is

allowed to function as an air vent from beneath the dressing. This may be converted into an irrigating vent, if so desired. The constant traffic of air, or irrigating fluid, through the tube maintains the lumen. Blood and serum are allowed to seep into the tube where they are sucked out. The suction end of the tube and the air vent are usually brought out through opposite ends of the incision, but they have been, on occasions, brought out through stab wounds distant from the incision. The end of the tube that is allowed to function as an air vent might be made smaller by placing a clamp on it or simply tying a ligature around the tube. This procedure is useful because sometimes it is important to create more suction inside the wound to allow compression of the flaps by atmospheric pressure. The ordinary Gomco suction, usually employed for gastric decompression, is used to maintain constant suction. As long as the tube is bubbling it is functioning properly. If it stops bubbling, it might be necessary at intervals to apply hard suction with a motor suction pump.

This type of wound suction drainage has been used in many different types of surgical incisions and traumatic wounds. Following upper abdominal surgery, especially where pancreatitis is a likely complication, the tube is placed behind the stomach through the lesser sac with one end of the tube as an air vent on one side of the abdomen, and the other end on the other side of the abdomen. The tube is then allowed to bend

*Supplied by Dow Corning Aid to Medical Research, Midland, Mich.



The holes are numerous and smaller than the lumen of the tube, so that anything that is sucked into the tube is not large enough to stop it up.

gradually so as not to kink. It is thought that removal of the fluid that accumulates about any anastomosis in this area will almost guarantee its integrity; probably the greatest cause of anastomotic disruption is the accumulation of this "foreign material" around the closed duodenal stump or gastroduodenostomy. With constant wound suction these anastomotic areas are allowed to heal dry. As much as 200 cc. of liquid material has been removed from the upper abdomen every eight hours in this type of case. In the lower abdomen, when the anastomosis is within the peritoneum and the area is not quite dry, the tube will function in the same manner to allow the anastomosis to heal dry. Probably it is not necessary to use this type of drainage in abdomino-perineal resections as gravity is sufficient.

This type of drainage has been used in radical neck dissection with resection of the mandible and other operations of less magnitude in the neck.

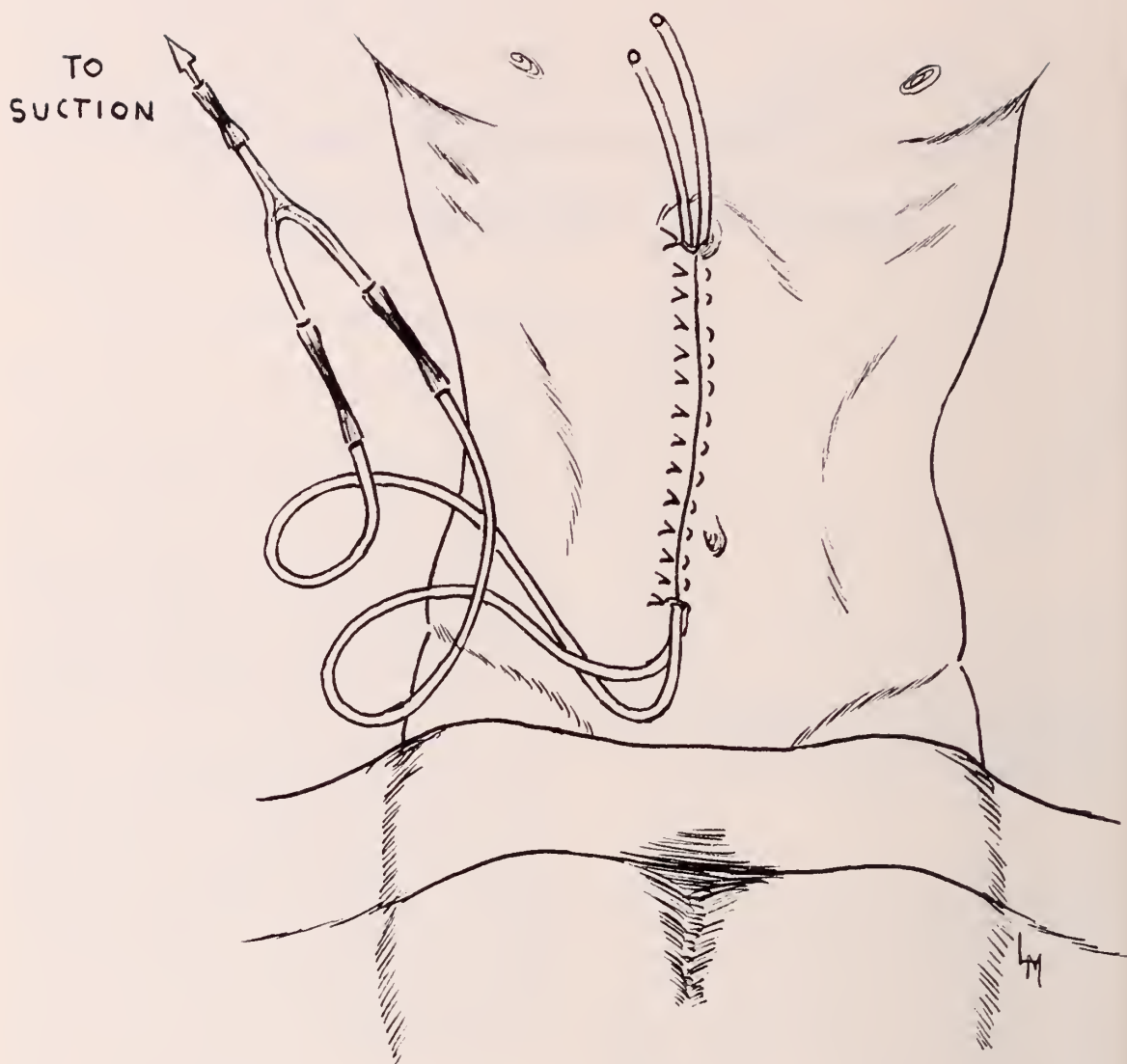
Here this technique is ideal because the thinness of the flaps allows one to ascertain at a moment's notice whether the tube is working or not. One or two Silastic tubes are placed in the wound so that the tube is away from the suture line. Suction is applied as soon as the last stitch is placed, so that the air cannot get into the wound. The skin collapses into the underlying defect, conforming to the irregularity perfectly. This procedure allows the wound to heal dry, prevents fistulas into the mouth, or fistulas that might otherwise have developed with tracheostomy openings.

It is impossible to make any breast wound completely dry, and this type of decompression of radical mastectomy wounds and simple mastectomy wounds is ideal. Again, atmospheric pressure produces a tailor-made pressure dressing. It is not necessary to apply a bulky dressing; simply a few thin layers of gauze with adhesive tape will be all the dressing that is needed. The usual technique for radical breast wound is to place two tubes, one behind and one in front of the axillary structures, with both of the air vents coming out on the top of the shoulder. The air vent is adjusted so that a proper amount of suction will allow atmospheric pressure to collapse the skin into the underlying defect. If a split-thickness skin graft is needed, it is simply cut to fit the defect and sutured with a continuous suture so that it will be airtight. The suction tubes are placed away from the graft and the graft will be held against the chest wall snugly, and take well.

Large incisional and umbilical hernias constitute the same hazard, large dead spaces in which blood and serum accumulate leading to delayed healing or even wound infection. Suction drainage will allow the flaps to collapse dry against the fascia.

The wounds following pilonidal cystectomy are most difficult to get to heal primarily. The experience with this type of suction drainage has been limited, but it appears that it might offer promise.

Smaller tubes, with smaller holes, have been used in hand wounds and they work well, allowing the skin to fit the underlying defect, and in most cases allowing the wound to heal dry.



Some wounds are so constituted that a loop of a continuous tube cannot reach the corners. Such a wound may be encountered in osteomyelitis. It is advisable in these cases to use a double-lumen sump drainage tube so that the point of the tube will go into the deepest recesses of the wound.

Conclusion

Obliteration of the dead space is still the greatest deterrent to primary wound healing. The most abundant material that collects in a wound

is liquid. This "foreign matter" not only separates the wound margins, but also furnishes an ideal medium for bacterial growth. This material may be sucked out with a tube that is inert, allowing atmospheric pressure to custom-build a pressure dressing that causes the tissues to fill up the irregularities of the wound and allow primary healing. A Silastic tube, with an adjustable air vent, has been used for this purpose and has been found to work satisfactorily.

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Panama City 32401

New Way to Remove Fishhooks

TIM M. SMITH, M.D.

Fishhook removal in Florida, as elsewhere, is a minor but often troublesome problem to the physician. In many of our seaport towns, it is a common occurrence.

In 1961, Dr. Theo Cooke reported in the Medical Journal of Australia (June 3, 1961, p. 815) a new method of removing fishhooks which was performed in a simple painless way, without the benefit of anesthesia and in jig time. This method was taught to him by the fishermen of the area near Port Vincent on St. Vincent's Gulf, South Australia. Dr. Cooke noted that very few of his medical colleagues had heard of it, and I am sure that few of my colleagues have heard of it. He reported using it on only three patients and it was unsuccessful in one case.

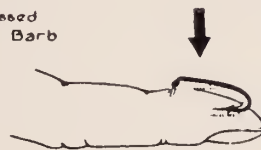
Method

Since 1961, I have removed more than 50 fishhooks by this method, in the private practice of medicine here in Panama City, with virtually 100% success. The following description of exactly how to proceed is quoted directly from an article published in an Abbott's Tempo of 1961, relating what Dr. Cooke had written: "The person who is to remove the hook makes a loop of ordinary string and winds the end securely around his right index finger. The loop, about 18 inches long, is slipped over the shank of the hook. The finger which the hook has entered is placed on a firm surface with the eye of the hook pointing to the left of the manipulator who then takes the eye and shank between the thumb and index finger of his left hand, which rests on the patient's hand. Holding the shank rigidly, he depresses it, painlessly disengaging the barb unless the hook is moved sideways. He slowly straightens the loop

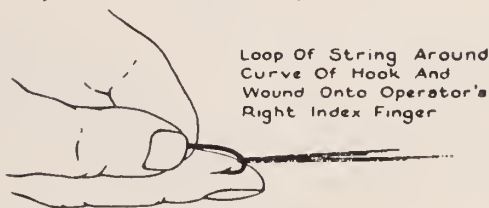
of string horizontally in the plane of the long axis of the shank. This is a test maneuver to make sure the loop will not become tangled on coat buttons and to bring the center of the loop gently against the curve of the hook.

"The tip of the operator's left third finger then holds the center of the loop against the finger at the point where the hook enters. The operator brings his right hand back to the hook and suddenly jerks it away again in the same

Shank Depressed
To Disengage Barb

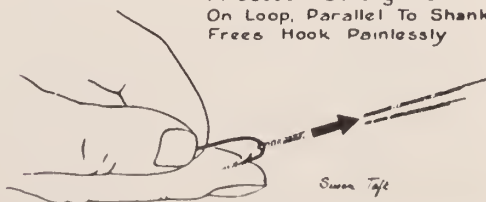


Eye Of Hook Steadied By Operator



Loop Of String Around
Curve Of Hook And
Wound Onto Operator's
Right Index Finger

A Sudden Strong Pull
On Loop, Parallel To Shank
Frees Hook Painlessly



Dotted line indicates position of hook after being depressed. Arrow indicates direction of pull on the string. Illustration reprinted through courtesy of The New England Journal of Medicine, March 10, 1966.

direction as in the test maneuver, with full follow-through. The hook is spun back out of the finger without enlarging the track or the hole of entry. For hooks larger than a size 1 whiting hook, a double loop 24 to 30 inches long is used and Cooke states that full sized snapper hooks present quite a different mechanical problem." (The latter statement is not true in my experience.)

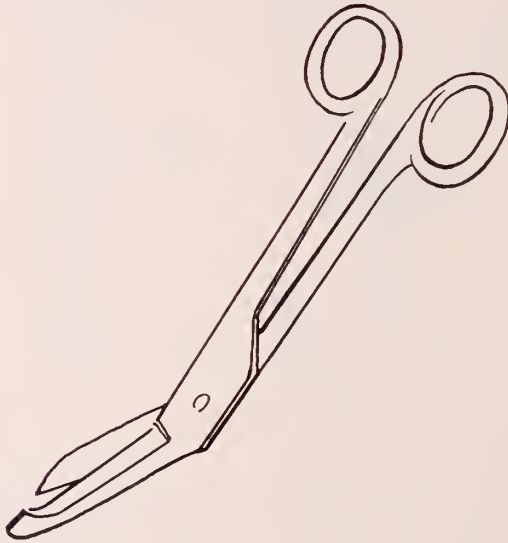
In my total of 50 plus cases, the only two failures I have had were due to the fact that the patients had clipped off the fishhook at the level of the skin leaving only a very short projection protruding. I attempted to remove these hooks by clamping a hemostat on the small projection and using the same method, but it failed. No

failures of removal occurred when the hook was left intact by the patient.

Hooks were removed from most all areas of the body, but the hands, scalp and legs were the most common sites of involvement.

The only drawback to this method, as I see it, is that it is so simple the patients are somewhat reluctant to give you your fee for removing the fishhook. Also, it is somewhat difficult to get up enough nerve to perform the procedure for the first time since it requires a sharp jerk and the operator is somewhat hesitant to proceed without benefit of anesthesia.

►Dr. Smith, P.O. Box 4588, Panama City 32401



Endotoxin Shock

WILLIAM C. FONTAINE, M.D. and JAMES D. NIXON, M.D.

The clinical picture of obstetrical sepsis has changed in the past two decades. Previously, patients died of generalized peritonitis, septic infarction of the lung, or overwhelming infection. In the recent past and at the present time, a triad of clinical pictures may precede death. Endotoxin shock, renal failure, and intravascular hemolysis are varying clinical manifestations of the "new look" in obstetrical sepsis.

Until recently, we did not appreciate the existence of a separate type of shock caused by bacterial substances. Shock used to be classified into four distinct types:

- (1) Cardiac failure — inability to act as efficient pump.
- (2) Neurogenic — caused by a breakdown of the vasoconstricting mechanism.
- (3) Vascular obstruction — as cardiac tamponade or embolism.
- (4) Hypovolemia — caused by decreasing vascular content.

It was assumed that bacterial shock was a variant of one of these four types.

Recent investigation shows that endotoxins from various gram-negative organisms, when injected into animals, cause a picture indistinguishable from that of gram-negative bacterial infection.

Review of mortality rates reveals that in spite of the increased use of transfusions, cortisone and modern day antibiotics, the mortality rate of "septic abortions" has not decreased appreciably in the past 20 years. This fact, coupled with a different understanding of the mechanism of shock, has led us to understand that the important factors are no longer the recognition of the bacteria or the choice of antibiotics but the site of the infection and its toxicity. Two main

groups of infections present serious toxicity in pregnancy:

1. Endotoxins are large molecular weight lipopolysaccharides, not specific to any strain of bacteria, although their distribution seems to be in the gram-negative group, and they are liberated on the destruction of the bacterial cell wall. This group includes *Brucella melitensis*, *Salmonella typhimurium*, *Escherichia coli*, *Pseudomonas aeruginosa* (pyocyanea), *Proteus vulgaris*, and *Aerobacter aerogenes*.

2. Exotoxins are enzymes and they create a variety of toxic effects. *Clostridium welchii* is the outstanding example in this group.

A case is reported that points to the important questions of where the infection is, the severity of the toxicity and what has to be done in the light of the newer knowledge:

Report of Case

A 24 year old white woman was a gravida V, Para II, AB II. Her last menstrual period was Jan. 8, 1965 and her expected date of confinement was October 15. She was hospitalized on August 28 at 11:30 a.m. with a history of ruptured membranes on August 26 at 8:00 p.m. At that time, she was admitted to another hospital but discharged a few hours later apparently not in active labor. She allegedly had no elevation in temperature and fetal heart sounds were audible.

On physical examination at the time of admission her temperature was 105.4 F., blood pressure 120/80 mm. Hg and pulse rate 90. The abdominal examination revealed a fundus midway between the umbilicus and the xiphoid process. No fetal heart sounds were heard. Vaginal examination revealed a vertex presentation, station -1, two centimeters dilatation. Initially 500,000 units of aqueous penicillin was given intramuscularly and thereafter 200,000 units every three hours. Intravenous fluids were started. Labor progressed slowly and she was delivered spontaneously of a premature stillborn female infant at 10:10 p.m. The temperature at the time of delivery was normal and was 98.4 F. six hours postpartum. It rose to 102.2 F. at 12 noon on August 30, but hyperpyrexia was not an essential feature. Minimal bleeding occurred at the third stage of labor and lochia rubra for three to five days. By midnight, the blood pressure was 70/40 mm. Hg and then dropped from this

pressure to 60/0 mm. Hg. The pulse gradually increased to 140, became weak and thready and air hunger followed. A central venous pressure was established and this showed no evidence of hypovolemia. Urinary output in the first 12 hours postpartum was less than 100 cc.

More intensive therapy was started with intravenous chloramphenicol (Chloromycetin), streptomycin and tetracycline. Intravenous Aramine drip was started; hydrocortisone 400 mg. intravenously and mannitol 50 cc. intravenously were administered. When sufficient time for clinical response had elapsed with no improvement, it was decided that elimination of the source of the endotoxin was necessary and 24 hours postpartum, total hysterectomy was performed. Grossly, the endometrium looked necrotic and showed an acute metritis microscopically. Postoperatively, the urinary output hourly was 250, 200, 200, 150, 130, 125, 270, 150, and was 2,690 cc. in the next 24 hours. The blood pressure became stable within 12 hours without the use of Aramine, and uterine culture revealed the offending bacteria to be *Aerobacter aerogenes*. The patient was discharged on September 12.

This clinical picture was seen in the third trimester; however, it can be seen at any time, but usually in the earlier months of pregnancy. We should anticipate this possibility in any infected obstetrical patient. When one is examining a septic abortion, part of the routine pelvic examination should include smears for gram stain and culture from the cervix or uterine cavity and an attempt should be made to empty the uterus with a sponge forceps. Laboratory work should include CBC, BUN, blood culture, type and cross match and clot observation test and examination

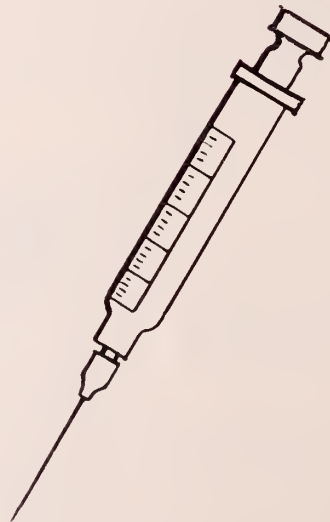
of serum for hemolysis.

Therapy should include 1 Gm. of chloramphenicol in 200 cc. of 5% glucose in H₂O given intravenously in 30 minutes, 4 to 6 Gm. intravenously every 24 hours in divided doses and 2 Gm. every 24 hours in the recovery period, up to 500 mg. of hydrocortisone and 250 mg. every four hours with reduction during the recovery phase.

The status of vasopressor substances is at present controversial, but should be clarified in the near future when the exact mechanism of shock is understood. The best results at present are obtained with Aramine 250 mg. to 2 Gm. per liter in 5% glucose in water depending on the response. Serial venous pressure readings act as a guide to hydration and blood replacement. Massive doses of penicillin should be added if *Cl. welchii* is cultured. Doses up to 30,000,000 units in 24 hours may be necessary.

A strong plea is made to recognize that the toxin is liberated after lysis of the cell, and at least for the present, only surgical removal will result in clinical cures. The intensity of the treatment will depend on the intensity of the toxicity.

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Listeriosis in Pediatrics

JOHN J. BENTON, M.D. and WILLIAM F. HUMPHREYS JR., M.D.

Infections with *Listeria* organisms occur in many different species of animals. The purpose of this paper is to direct attention to two cases of human listeriosis from Northwest Florida.

Listeria (or *Listerella*) is a genus of gram-positive, small, motile, coccoid or diphtheroid-like organisms. The type species is *L. monocytogenes*, which has been recovered from farm animals, wild animals and birds, and also from ticks, flies and mites. The organism has been found in all parts of the world. In veterinary medicine, listerial infection of the central nervous system is well known in the large domestic animals and is called circling disease, grass tetany or pseudorabies. An excellent review of listeriosis appeared in the September 1964 issue of *Pediatrics*.¹

The two cases reported illustrate several of the features of listerial infections encountered in pediatrics:

Report of Cases

Case 1.—Listerial Meningitis: A three week old white female premature twin was in apparent good health until April 24, 1953, when she became "fussy," and had moderately loose stools, very high fever, and five generalized convulsions prior to her admission to Memorial Hospital, Panama City.

The patient was born at the Washington County Hospital, Chipley. She was the first of twins, was delivered from breech position apparently without difficulty, and breathed spontaneously. Birth weight was 4 pounds, 10 ounces. Her color was good until the present illness.

The mother, father and older siblings (ages four years, two and one-half years and 14 months) were in good health. The twin brother was doing nicely and had had no difficulty since birth. The family lived on a farm where there were cows, hogs and chickens. No sick animals had been in close contact with the patient or around the house.

The patient was an acutely ill infant with marked abdominal distention and rectal temperature of 104 F. The skin was mottled; there was mild cyanosis of the nailbeds. No eruptions were noted. There was slight resistance to flexion of the neck. The anterior fontanelle measured $2\frac{1}{2}$ by $2\frac{1}{2}$ fingerbreadths and was bulging. The head circumference was $12\frac{3}{4}$ inches. There was no palpable enlargement of the spleen, liver or kidneys.

A lumbar puncture yielded slightly cloudy spinal fluid under moderately increased pressure. Examination of the fluid revealed 441 white blood cells, 125 red blood cells, total protein 200 mg.% and sugar 40 mg.%. On direct smear, a gram-positive rod was seen intracellularly. The blood and spinal fluid cultures were positive after 24 hours for the same type of organism, and this organism was identified (by our laboratory and the Florida State Board of Health Laboratory and also confirmed by the U. S. Public Health Communicable Disease Center Laboratory at Chamblee, Ga.) as *Listeria monocytogenes*. The baby's blood count on admission showed 19,200 white blood cells (with 83% polymorphonuclear leukocytes, 2 juveniles, 48 stabs and 17 lymphocytes), 3.8 million red blood cells and 10.3 Gm. hemoglobin. Urinalysis was essentially negative, other than one plus albumin. The stool culture was negative. Disk sensitivity tests revealed the gram-positive bacilli highly sensitive to streptomycin, chloramphenicol (Chloromycetin), erythromycin (Ilotycin), chlortetracycline (Aureomycin), oxytetracycline (Terramycin), penicillin, and sulfonamide, but not sensitive to Polymyxin B.

Immediately following the spinal puncture and the drawing of blood for culture, treatment was begun with penicillin, streptomycin and oxytetracycline. After seven days the streptomycin was discontinued as the patient's progress had been satisfactory, she was afebrile, nursing well, and appeared to be in fairly good general condition. The fontanelle tension was normal by April 30 and on May 5 all medications were discontinued.

On May 9, there was definite bulging of the fontanelle and a lumbar puncture released xanthochromic fluid with 100 white blood cells (35 polymorphonuclear leukocytes, 65 lymphocytes). The protein content was 242 mg.%; sugar was 33 mg.% and culture was negative. Antibiotic therapy was resumed.

Subdural taps on May 19 indicated that the child had bilateral subdural effusions. Repeated subdural aspirations approximately three times a week for two months failed to effect a cure. The patient was transferred to Foundation Hospital, New Orleans, La., for neurosurgical treatment. There it was established that, in addition to the subdural effusions, she had porencephalic cysts of the frontal lobes. The child was given the benefit of surgical treatment, but showed worsening hydrocephalus in the following weeks and developed poorly. When last seen at the age of seven months, she was unable to hold up her head. The family moved away from this area and we have no later information on this patient.

Case 2.—Neonatal Listeriosis (sepsis): An infant, at the age of 27 days, was admitted to Memorial Hospital on the night of Feb. 24, 1964 because he had suddenly stopped breathing. He had seemed to be doing well since his release from the hospital 12 days previously until, when gotten up for his 9 p.m. feeding, he suddenly stopped breathing, turned pale and then turned blue.

There had been no choking, no fever, no feeding difficulty or other evidence of illness earlier in the day. The infant was given mouth-to-mouth resuscitation by the father and rushed to the hospital. He began to breathe again at about the time he arrived at the hospital.

The patient was born in Memorial Hospital on Jan. 28, 1964 to a 19 year old primigravida by normal delivery. The birth weight was 5 pounds, $\frac{1}{4}$ ounce. The mother's history indicated a gestation of about seven months. The baby was rather sluggish, never cried well and was a poor eater. He lost weight down to 4 pounds, $10\frac{1}{2}$ ounces, then slowly gained to 5 pounds, 1 ounce on February 12, the day he was discharged. The blood count was normal. Blood culture was not made during this time.

The mother gave a history of having had, some weeks before delivery, a fever attributed to a dental abscess. There was no illness apparently precipitating the premature labor.

On admission, the baby's hemoglobin value was 11.0 Gm., hematocrit reading 32%, and white blood cell count 7,050 with 36% segmented cells, 1 band, 1 eosinophil, 61 lymphocytes and 1 monocyte. Urinalysis was essentially negative. Cerebrospinal fluid had two WBC/mm³, sugar 64 mg.%, and protein 61. Admission blood culture grew out *Listeria*—"gram-positive pleomorphic rods"—in about five days; positive identification as *Listeria* was not made until four days thereafter. Subsequent blood cultures were negative. During the hospital stay, BUN, blood calcium and an electrocardiogram were normal.

The infant was in critical condition for many days. He had two more episodes of apnea during his first night in the hospital. His breathing was at times shallow and irregular. He showed variable cyanosis even with oxygen therapy. He was listless and nursed poorly. Clinical and x-ray evidence of bilateral pneumonitis developed. He seemed closest to death nine days after admission, then steadily improved so that his condition was good by March 9. He was afebrile throughout the illness.

This patient was treated with oxygen, nikethamide (Coramine), blood transfusion and gamma globulin as well as at one time or another penicillin, kanamycin, sodium methicillin (Staphcillin), erythromycin estolate (Ilosone), sulfisoxazole (Gantrisin), Mysteclin-F and chloramphenicol. The last two were used longest and seemed effective. Laboratory tests with the *Listeria* culture showed the organism to be sensitive to bacitracin, chloramphenicol, chlortetracycline, erythromycin, nitrofurantoin, penicillin and tetracycline.

The infant was discharged on March 14 and has enjoyed good health since then. He has developed normally.

After the diagnosis of listeriosis was made, the parents were asked specifically about animal contact. The mother had been around cats and dogs much of her life but not around farm animals. Culture of the cervix uteri of the mother did not yield *Listeria*, but serologic test of her blood showed anti-*Listeria* antibodies.

Comment

Meningitis due to *Listeria* occurs mostly in young children, especially in infants under one month of age, and in persons over 40 years of age. Many of the neonates with listerial meningitis have concomitant sepsis. Many of the examples in older persons are superimposed on chronic or debilitating illness.² Fatality figures of 50% to 75% have been quoted for listerial meningitis.³

Sepsis due to listeriosis is typically seen in a premature infant, often after eight or 10 days

old; frequently there is evidence of a mild infection in the mother during pregnancy. In this latter regard, the situation is analogous to rubella infection in the pregnant woman; the disease may be mild or inapparent in the woman but devastating in the fetus. A blood culture is indicated in any pregnant woman with an unexplained febrile illness.

Listeria monocytogenes may sometimes be present in the maternal vaginal or cervical secretions, suggesting that the infant acquires his infection at birth; transplacental infection before birth evidently occurs in other cases and cord blood cultures may be positive. Gram stain of meconium may show large numbers of organisms,⁴ permitting more rapid diagnosis than possible with cultures.

Listerial infection in the woman's reproductive tract has been reported by Rappaport et al.⁵ to be a cause of repeated abortion. Certain other investigators, however, have been unable to confirm this thesis.^{6,7}

Listeria may be slow to grow in culture and before positive identification is possible, may be mistaken for a diphtheroid. When a preliminary bacteriological report of diphtheroids is given but the source material for culture could not be expected to yield diphtheroids (for example, cerebrospinal fluid or blood), *Listeria* should be suspected.

Listeria monocytogenes is usually susceptible to a number of the available antibiotic drugs, as tetracyclines (perhaps the drugs of choice), erythromycin, chloramphenicol, kanamycin, and penicillin. With proper and prompt therapy, the case fatality rate for serious listerial infections is reduced to 20% to 25%.⁸

Summary

Two cases of listeriosis in infancy are presented. Both patients were critically ill infants who were born prematurely. One patient had meningitis as well as sepsis, complicated by subdural effusions and porencephaly and was left with damaging neurologic sequelae. The other patient had sepsis without meningitis and recovered completely.

References are available from the authors upon request.

► Dr. Benton, 316 W. 11th St., Panama City 32401

Therapeutic Community-Orientated Psychiatric Inpatient Unit

Follow-Up Study of First Five Hundred Patients Treated

JOHN F. CLUXTON, M.D.

Many follow-up studies have been reported on large numbers of patients discharged from veterans and state hospitals and long term treatment private psychiatric hospitals. Follow-up studies on acute treatment, therapeutic community-orientated psychiatric hospitals are few and on relatively small numbers of patients. This study was designed to define the results of treatment of the first 500 patients of a university center psychiatric hospital which was operated as an open door, therapeutic community, psychodynamically orientated psychiatric unit.

This unit runs an average census of 30 patients. Both male and female patients live on the same ward. The individual psychotherapy is done by first year psychiatric residents under the supervision of staff psychiatrists. The individual therapeutic time spent with each patient varies from 30 minutes twice a week to an hour three times a week, depending upon the need of the patient. This unit offers a graded activity and occupational therapy program so that the patient can participate in activities in keeping with his functional level at any particular time. The majority of the patients are treated with group psychotherapy and family psychotherapy as well as individual psychotherapy. Drug treatment and physical treatments are used as an adjunct to the psychodynamically orientated treatment.

The ward is operated as a therapeutic community in that there is a patient organization through which the patients share as much responsibility as possible for running the unit itself. The unit is unusual also in that there are usually more staff and students on the unit than there are patients. The nonpatient personnel generally wear street clothes so as not to distinguish them from the patient population.

Patients are all referred to the Center. Ninety-five per cent of the patients are self-paid patients. Sixty-five per cent of the population surveyed were women. The age range of these patients was between 14 and 92 years. Five per cent of them were under 20 years of age, 40% were 20 to 40 years of age and 55% were over 40 years of age. Diagnostic distribution ranged from 42% psychotic illnesses, 40% psychoneurotic illnesses, 11% personality and behavior disorders and 7% organic syndromes. The average period of time that the patient stayed on the unit was below three months, in that 19% stayed less than two weeks, 59% stayed two weeks to three months, 17%, three to six months and 5% longer than six months. Disposition of these patients on discharge was that 12% were transferred to long term inpatient treatment situations, 67% were referred into some form of outpatient psychotherapy.

Prepared during residency, University of Florida Teaching Hospital, Gainesville.

Results

Of the first 500 patients on the unit, 82% were successfully followed up. The time of follow-up ranged from six months to five years after discharge. The follow-up technique was to send a multiple choice questionnaire through the mail to the patient which inquired into such factors as ability to return to previous level of functioning, symptoms since discharge, treatment since discharge, change in marital adjustment and status since discharge, and a judgment of what was the most helpful aspect of their inpatient treatment program. Those who failed to respond to the mail questionnaire were contacted by telephone when possible, and the questionnaire was completed in this way.

Follow-up results indicated that 80% of the patients returned to their previous level of productivity, 7% had required rehospitalization, 55% had continued in long term outpatient psychiatric treatment, 42% were asymptomatic and 36% were minimally symptomatic, 11% had been divorced or separated since discharge from the hospital and 40% reported an improvement in their marital adjustment. Eleven patients had died of natural causes and 10 patients had committed suicide since discharge.

Comment

In reviewing these results, one sees that 80% of the patients were cured in the sense that they were able to return to their previous level of functioning in an average period of three months of hospital treatment. This represents an effective psychiatric hospital treatment program when viewed from the perspective that this population represents a large percentage of patients who had been treated in other psychiatric facilities before referral and had failed to respond to treatment. In view of this degree of effectiveness, the basic operating principles of this unit should be considered for use in the Community Mental Health Centers which are being developed as a result of the recent Federal Comprehensive Community Mental Health Centers Act.

The first point to be considered is that this unit, though using drug and physical treatments as an adjunct to psychotherapy, operates primarily as a psychodynamic unit, with emphasis primarily

on the individual psychotherapy, group psychotherapy and family psychotherapy.

The second point is that this unit had a variety of activities in which the patient could become involved. These were social and recreational activities, conducted both on ward and off ward, which ranged in complexity so that the patient could participate in activities in keeping with his capacity. There was also an active occupational program which was again a geared program so that the task was matched with the patient's capacity at any particular time.

The third point is that an attempt was made at every opportunity to mobilize the therapeutic potential that exists within the patient population. That is, the patients were encouraged to interact with each other both in structured and nonstructured situations; at times under the supervision of the therapist, as in the group psychotherapy situation; at times under the supervision of other mental health professionals, as in the occupational therapy and activity programs; and with the total staff in the patient-staff meetings; and without professional supervision in the social and recreational activities and in the nonstructured, spontaneous activities that arose on the unit. It was thought by the staff and also by the patients on follow-up that this was an extremely important adjunct to their individual psychotherapy.

The fourth point is that an attempt was made to give the patient a feeling that he was not detained or locked up and that he had influence over his environment. This was accomplished through the open door psychiatric hospital policy and also by the patient-staff organization in which the patients could actually influence their activity programs, make complaints about staff personally or collectively and generally influence the operating policy of the unit.

The fifth point is that the high number of nonpatient persons on the unit tended to dilute the manifest psychopathology. Also the patient's surroundings were kept as much as possible like a home situation and the behavior expected of the patient was in keeping with his surroundings. It is important to note that the patient organization played a definitive part in encouraging deviant patients to maintain this standard of behavior.

The final point to be considered is that about 90% of the families were actively involved in

some form of family psychotherapy in an attempt to help them understand their part in the dynamics of the patient's illness and help them to change the part they played in a constructive direction.

Conclusion

In summary, 82% of the first 500 patients in a psychodynamically orientated, therapeutic com-

munity psychiatric inpatient unit of a university hospital were followed up by questionnaire. The type of treatment and patient characteristics were defined. Eighty per cent of the patients were returned to their previous level of adjustment in an average period of three months' hospitalization.

►Dr. Cluxton, Bay County Guidance Clinic, Panama City 32401

Scientific Papers and Exhibits Sought for 93rd Annual Meeting

Applications are now being accepted for scientific papers and exhibits to be presented before the 93rd Annual Meeting of the Florida Medical Association, May 11-14 at the Americana Hotel, Bal Harbour. Applications were included in the September Briefs. Additional applications may be obtained by writing Russell B. Carson, M.D., Chairman, Committee on Scientific Work, P.O. Box 2411, Jacksonville, Florida 32203.

Applications must be submitted no later than January 1, 1967. The Committee on Scientific Work will make selections and notify contributors of acceptance shortly thereafter.

Important Note: All applications for scientific papers to be presented before the 93rd Annual Meeting of the Florida Medical Association must be accompanied by a one page (200 word) summary of the paper prepared for publication in the Journal of the Florida Medical Association. These summaries will be published in the Journal prior to the Annual Meeting.

Symposium on Adolescence

New Orleans, Louisiana

December 1-3, 1966

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George Tarjan, M.D., Professor of Psychiatry and Program Director of Mental Retardation Project at University of California in Los Angeles, Calif.

Carroll Witten, M.D., President-Elect of American Academy of General Practice, Louisville, Ky.

Symposium will be held at the Fontainebleau Motor Hotel, 4040 Tulane Ave., New Orleans. Early hotel reservations are recommended.

AMONG TOPICS TO BE DISCUSSED:

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"Parents of Problem Children"

"Handling of Adolescents by General Practitioners"

"Sexual Morality—A College Dilemma"

"Drugs in the Treatment of Children and Adolescents"

"Learning Problems of the Adolescent"

"Adolescence and Social Mores"

"Talking About Sex with Adolescents"

"Religious Psychological Conflicts"

Gene L. Usdin, M.D.
Director of Psychiatric Services
Touro Infirmary
1400 Foucher Street
New Orleans, Louisiana 70115

Enclosed is my registration fee of \$20 for the SYMPOSIUM ON ADOLESCENCE to be given December 1-3, 1966 at the Fontainebleau Motor Hotel. (Checks should be made payable to Touro Infirmary.)

Name _____

Address _____

President's Page



Physicians, Politics, Positive Influence

Legislation, medical care programs and physicians are inextricably interrelated and bound together. Any medical care program must be written and passed in its final form by legislators, administered and regulated by civil servants and government appointees, and the actual medical services provided by physicians. Logically, then, it follows that the type of medical program produced depends upon the type of legislators elected.

Physicians have obvious reasons for becoming actively interested in politics. First, a physician is an educated and intelligent citizen and he owes it to himself, his family and his community to be vitally interested in all elected officials who govern him and who make the laws, rules and regulations under which he lives and practices his profession. Second, as a professional man providing medical care to his patients (our citizens), he is an acknowledged expert in the field of health care and he should be eager to have men in public office who are likewise intelligent and who will provide the type of programs in the best interest of those citizens who will be eligible for the benefits.

Title 19 of PL 89-97 contains health care programs which will profoundly affect many more of our citizens than Title 18. We must do all we can to influence, advise, consult and work with those who will formulate and write the program. We must support and elect those legislators whose philosophy is such as to produce programs of all kinds (not only medical and health) which are in the best interest of our citizens and which do not tend to erode and destroy what we call Individual Responsibility.

We must join, support and contribute to FLAMPAC which in recent years has been only weakly effective politically. FLAMPAC is stirring and becoming vigorous under active, energetic leadership. We can make our votes be heeded and needed and our voice be heard. Our influence for better government will be strong if we all pitch in united. Remember 1950? Get to know and talk with those legislators and other officials who you think are best suited to represent you. Let them know how you feel. Let them know you are available to aid and advise. FLAMPAC is ready and willing to be our political arm. We must keep it strong and effective by active and significant personal and financial support.

*The freeman casting with unpurchased hand
The vote that shakes the turrets of the land.*

A Metrical Essay—Oliver Wendell Holmes

George S. Palmer

New low-cost tetracycline/antifungal therapy

for broad-spectrum activity
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Whenever tetracycline is indicated in these candidates for Candida:

1. diabetic patients



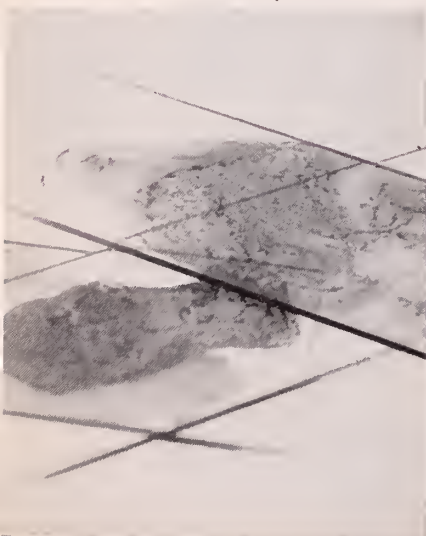
2. nonpregnant women with a history of recent or recurrent monilial vaginitis



3. elderly or debilitated patients



4. patients with a past history of moniliasis



5. patients on long-term tetracycline or corticosteroid therapy



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*Schiller, I. W., and Lowell, F. C.: New England J. Med. 261:478, 1959.

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Special Articles

Obsolescence or Learning

RICHARD P. SCHMIDT, M.D.

Two years ago on a similar occasion, I used a quotation from Osler to develop a theme for my address to the graduating class. It was taken from his Valedictory address to the students of McGill University in 1905.¹ Osler was a great teacher and he gave many speeches, most of which have been preserved to help others give graduation talks. I will not, however, quote him again at this time. Suffice it to state that his concern was that of life-long learning or the continuing education of the physician. I bring Osler into my presentation because of his prominence during the time of a previous convulsion in American medicine about the turn of this century. The prior torment was that of the quality of education for the profession of medicine, and its result was the closure of most of the then existing medical schools because they could not meet the test of quality or of inquiry. The final decisive cut was delivered by a school teacher, the master of Mr. Flexner's School from Louisville, Kentucky, who published his study in 1910.

After the Flexner Report on Medical Education in the United States and Canada² medicine

cleaned its house. The American Medical Association took a leadership role in establishing standards, in the rating of schools and ultimately in helping to set standards for postgraduate programs. Medicine became an academic pursuit educationally based in the university. The spirit of scientific inquiry became the bedrock upon which the house of our art was built. This was also a period of other far-reaching changes in America and in the world. Some of these with wide impact were: Universal education at public expense, the graduated income tax, mass transportation and communication, the recognition of the principle of collective bargaining, the assembly line, suffrage for women and World War I. I will neither defend nor decry that which happened then. I mention them for us to keep a social perspective upon medicine. The dictatorship of the proletariat was also shortly to become a reality with the overthrow of the Czars and of the Keren-sky Republic.

Today, we are again (or still) facing a turmoil in the world and in medicine. I do not speak only of the changes in social order nor of the manner of paying for health care and medical services. With these, all of us are and will be concerned, and we will agree or disagree from time to time.

¹Associate Dean, University of Florida College of Medicine, Gainesville. Address delivered at College of Medicine Commencement Convocation, June 5, 1966.

I prefer to speak more of a second major reform in medical education which will, I am convinced, be as far-reaching as were the results of the Flexner Report in the era of Osler.

I have recently read a series of articles on education for science or for science-based professions. I find in these that the substitution of the words "medicine" and "physician" for "physics" and "physicist" or "engineering" and "engineer" would be entirely appropriate. Peppered throughout are the new catchwords, such as "knowledge explosion," "brain-bank" and "space age." We in medicine are not alone. If the engineer becomes obsolete within three years of his graduation, how long will it take you? How many of us now teaching or now in practice are obsolete? Our own Dean, though scarcely a year and a half away from the laboratory, already considers himself to be an obsolete microbiologist. We will forgive him for this since he no longer pretends to be one. His goals and duties are now broader.

Why do I use these words? They may appear to be insulting, but they are not meant to be. They do reflect, however, what I believe to be some of the facts of our lives. Knowledge is expanding. It is not just idle knowledge for those in ivory towers. It is good, firm, solid knowledge. It includes the capabilities of application for the betterment of man's health or even for its redefinition. If we use it well, we can help expand the capabilities of man. Those whom we serve know it is there and will want you to determine the direction of its use. We must not fear to lead in our own house. We in medicine must determine the needs of the people and work on the solution of the problems presented in meeting them. We may need more physicians and we may need different kinds of physicians. What of the roles for the other health professions? How can we work together most effectively? How best are we to train the physician oriented to the health of the family and of the community, and how are we to help him keep abreast of scientific knowledge? What should be the role of the specialist or of the medical center?

All of you are aware of the conflicts which sometimes arise between the university on the one hand and the practitioner on the other. We in the universities are not infrequently accused of trying to "take over" or of being like the octopus,

reaching our tentacles into the domain of the practitioner. At times we are guilty. We may well be taken to task for our failures to appreciate the problems of our colleagues in the town, and we may appear to emphasize his supposed errors and deficiencies. Even worse, however, we may not have given consideration to our responsibilities to him. What do we really do to upgrade his abilities?

Traditionally, the university has been a repository of knowledge and an arena of scientific investigation. This role does not infer ownership; perhaps it could be better described as stewardship. Even this word may be self-expansive.

Let us now return to that referred to as the second reform in medical education and outline a little of what I believe must be done.

You, the graduates, may now consider yourselves as leaving the university. The fact that you are entering internship programs signifies that you have not completed your education. You will find over the years that you will never be able to say that you have done so. We, your teachers, may similarly look upon our own responsibilities. We hope we have aided you in gaining the tools with which to learn your art, but can we say that our job is finished because you have received your diploma? I would rather phrase it to indicate that we give you this degree in our faith in your ability to learn and to continue to learn on your own responsibility.

The new reform in medical education will be in your learning henceforth in your medical careers. You and your colleagues must now work in the framework of your professional groups to set standards for quality which will continuously upgrade your capabilities or you will be in danger of obsolescence in a few short years. I believe it is time for us in the ivory tower to get out of it and enter into the education for the practice of medicine. By this, I do not refer to more courses in the practical aspects of our profession. We must work with you in planning a life of learning. Our responsibilities for continuing education must not be secondary. You and we should make these plans together. There should be no fundamental conflict between us, but we must permit each other freedom of expression and of inquiry. I believe we together must study the patterns of health care and how it may be improved. We, together, may

study means through which learning will continue to be part of your daily life without which you will slip back. I therefore call upon our graduates not to leave the university in spirit. I call upon you now to take leadership in developing ways that we may best serve you in years to come.

We of the faculty are proud of you and have confidence in your future. We do not say "farewell." We extend our congratulations, but we

hope that you will place increased demands upon us and that we will be able to meet them.

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1. Osler, W.: *The Student Life*, reprinted in *A Way of Life and the Selected Writings of Sir William Osler*, New York, Dover Publications Inc., 1958.
2. Flexner, A.: *Medical Education in the United States and Canada*. A report to the Carnegie Foundation for the Advancement of Teaching, New York, 1910.

►Dr. Schmidt, University of Florida College of Medicine, Gainesville 32601

Dedicated to Dr. Milton Sanes Goldman

Editor's Note: The Journal is pleased to publish the following poem as one of a series dedicated to her various physicians by Mrs. Leona Levin, a retired schoolteacher of Miami Beach who has been crippled by arthritis. Mrs. Levin writes under the pen name of Lena Lin Louis. The poems are presented as examples of all-too-rare expressions of gratitude to physicians. The doctors whose names appear have granted permission for their use.

T. M.

She hurts, she aches, she is always in pain
From morning to night you can hear her
complain.
She won't go to the doctor; she says she's too shy
She owes the ole Sage an arm and an eye.
Suffering beyond endurance, she pays him a visit
Has herself checked from beak to gizzard.
He finds she's the same, no less or no more
He prescribes she take her doses as before.
All through with her tests, she goes to get dressed.
The nurse goes out, to tend another ailing
old gout.
With great effort she is finally ready, alas and
alack,
She can't zip up her dress in the back.
She waylays the doctor and explains her plight,
He is in a great hurry but very polite.
He shakes his head and expresses much doubt,
"This is one operation I never learned about,
You have your dress on inside out."

Lena Lin Louis
Corny but sincere

Factors In The Admission Of Psychiatric Patients To A Long Term Treatment Center

THEODORE E. GAGLIANO, M.D.

To those of us who have been handling the admissions at a psychiatric hospital for the last several years, it has become increasingly apparent that there is a great need for definition of psychiatric services, within the profession and for the public at large. The volume of inquiry by telephone and by mail is astonishingly high. Queries are received from all walks of life. Most calls are from physicians seeking to place a patient in treatment. Calls are also received from clergymen, family and friends of the prospective patient. Occasionally, the prospective patient himself contacts the hospital. This paper represents an attempt to define our contribution in the psychiatric spectrum and describe some of the problems we have encountered.

Many of these calls have in common the need that something be done immediately about the problem at hand. It is at this point that difficulties begin to arise. The referring agency tends to generalize; and since this is a psychiatric hospital, we should be willing and able to take care of all psychiatric problems. Many of these referrals are of persons in the midst of an acute crisis at an unusual or inconvenient time and are actually being referred primarily because of the troublesome consequences of their illness rather than for treatment of the core problems.

Referral on this basis is certainly understandable and legitimate. These persons need treatment, and they need it urgently. It has been our rather sad experience, however, that acceptance of such patients at such times has not resulted in satisfaction for either the patient or the hospital.

For one thing, the situation is too confused and the disparity of goals too great. All too often the patients who come into the hospital in the midst of an acute crisis and are treated, frequently with dramatic symptomatic relief, are shocked and surprised when told that, in our opinion, their treatment is just beginning. To them, their treatment had been completed and nothing could appear further from the truth than the implication that the real problem remains to be attacked. As a result of this disparity, many patients sign out of the hospital against medical advice, occasionally with bitterness felt by all.

It is evident that a distinction can and should be made between those patients for whom short term supportive and re-educative treatment is sufficient and those patients for whom more extensive and intensive treatment is necessary. The former group is by far the larger and constitutes the bulk of psychiatric practice. We have chosen to focus our attention on the latter, smaller group. We think that short term supportive and re-educative treatment is available to those who need it and really want it. We also think that long term intensive treatment in depth is difficult to obtain and is urgently required by a part of the mentally ill population.

Preadmission Interview

Inquiries directed to the hospital are handled with these items in mind. An attempt is made, in a preadmission intake meeting whenever possible, to discuss and clarify the needs of the patient vis-à-vis the services offered by the hospital. These preadmission meetings are structured so

that a psychiatrist sees the patient, a social worker sees the person or persons who accompany the patient and the business office participates in establishing the financial realities.

Some sensitivity has been encountered regarding this procedure. Referring physicians occasionally think it reflects on their ability to make an appropriate referral. Sometimes it does, but more often it is merely a matter of determining, face to face, patient with hospital, the nature of the respective intentions and expectations. Once this preliminary step is accomplished, there is much less anxiety in all persons involved. This moment of truth is inevitable, but as just described, comes at a time and in a way which is much more favorable for all. Some patients and families decide not to use the hospital when they find out what is involved, but they would have come to this point anyway. More frequently, however, the fearful, apprehensive, and, therefore, resistive patient becomes more comfortable about the admission. This attitude is related to a number of factors, not the least of which are participation in the making of the decision, whenever possible, and the fact that he probably will not be admitted at the time of this interview.

This approach is all well and good, but what about the referring agency? It wants action and usually right now. This is a crucial point because it is unquestionable that many appropriate prospects for long term treatment have been lost because of a premature attempt to hospitalize them. It becomes exceedingly important, then, that the referring physician be familiar with our attitude and our goals toward treatment. Mutual understanding permits all concerned to take a position of maximum effectiveness.

Effective Approaches

One approach we have found most effective and useful has been to suggest that the patient be held on the psychiatric service of a general hospital until some of the issues mentioned have been clarified and resolved. Often the prospective patient is already there, which simplifies matters considerably. This procedure has proved most satisfactory, subject to the willingness of the general hospital to be used in this fashion.

Also effective is what might be called the sophisticated referral. In such a case, the patient

has been evaluated, or in treatment long enough, to establish the need for long term intensive treatment and this recommendation can be made before the development of an acute crisis.

Persons with addictive (usually alcoholic) problems probably constitute the most troublesome group. Motivation for treatment in these patients seems, more markedly than in others, inversely proportional to their symptoms. Most calls are received in behalf of these patients at night and on week ends. Usually these calls are frantic, and come from the family, the family physician or a friend. The patient's behavior has finally become so troublesome or anxiety-provoking that something must be done immediately.

It is not easy to deal with such calls. The usual and almost inevitable sequence of events in such cases is well known to us. So often in the past we have admitted the patients, only to have them sign out as soon as they are detoxified. This course does no one much good, and may well serve to perpetuate the pathologic condition.

The persons calling do not know of this probable outcome, however, and react in various ways to our reluctance to assume treatment responsibility immediately. Often they displace their frustration and hostility from the patient to the admissions officer who, as they perceive it, is refusing to help them. Nonetheless, they are encouraged to make an appointment for a pre-admission interview at the earliest feasible time. Many persons have sufficient recognition of the long term, and other aspects of the situation to agree to this, do it, and find it satisfactory; however, many do not, and when they do not get the action they want immediately, are never heard from again.

At best, it is a difficult situation—a bit like the house with the leaky roof. When it is raining it cannot be fixed and when it is not raining it does not need to be fixed. The fact of the matter, however, is that a person who drinks too much did not start drinking yesterday. Seldom is it true, if ever, that awareness of the problem does not exist in someone in addition to the prospective patient. Some responsibility must be assumed by such person or persons, preferably before the situation deteriorates into virtual impossibility or assumes crisis proportions and requires crisis management.

The attitude, then, of the family, the courts and the public at large is crucial, for this is where treatment support derives. We need support and supporters who recognize the nature of the problem and the difficulties involved in the treatment of the problem.

Summary

In summary, we want referrals—we need referrals—as a hospital, we cannot exist without them. We urge all who refer patients to us to be aware of and consider the treatment context of our hospital. We are geared for long term intensive treatment in depth along reconstructive lines. For some patients we constitute a sort of psychiatric

court of last resort. Other patients reach us before all else has failed and because it has been determined earlier that prolonged treatment is indicated. In still other cases, no one else wishes to attempt treatment for a variety of reasons. In all cases, we are dealing with extremely sick patients, and attempting treatment in situations where the outcome is often in doubt. Some of this doubt can be diminished and the effectiveness of all concerned can be increased by clarification of need and services and assignment of the proper role to all.

► Dr. Gagliano, Anclore Manor Foundation, Tarpon Springs 33589





In Which Direction Is American Medicine Going?

The tremendous currents affecting the social and economic life of Americans today are having similar effects on American Medicine. The forces at work, and the stresses within the profession, are ample causes for serious study and reflection.

Only a short time ago the doctor stood as an educated humane leader in his community, one of a relatively small group of citizens. By education, experience and temperament he qualified for this position. The remarkable advances of the past three decades in science and the great surges in education, however, seem to have lost the doctor in perspective. What seems to have occurred, since no one should be better educated in what it means to be human and what human needs are than the physician? Certainly our policies have not made for increased standing or better public relations except for the single advancement of individuals in technical excellence, and in the scientific developments from research.

The pressures brought to bear on the medical profession in the past three decades resulted in schisms which caused one group to turn on another within the profession. This development was exemplified in the vilification of the general practitioners, who used to make up the great majority of physicians, by some surgeons, publicly, and others whose education and experience were limited to a technical specialty. Perhaps this situation arose from the economic and other needs of the large number of specialists trained during and after World War II, as well as the great number whose experience became limited techni-

cally to one of the specialties. In technical performance medicine has forged ahead and kept pace, but in broader fields of living there have been increasing questions.

It would appear that the long term answer to this problem for the profession, and the people, is constant elevation of standards of qualification and education. Screening and preparation of future medical students could be begun in high school with a broader educational program in the premedical years in college. Psychometric tests and evaluations may be useful and psychologic education is as necessary as the broader classical education has proved to be. Universities and medical schools need tremendous amounts of money and large faculties of educated and dedicated teachers in raising future graduates to the level in general living upon which their forefathers stood. Highly trained technicians are necessary in large numbers, but should not preponderate in the medical profession to its detriment. The loss of control of hospital facilities by physicians has been a grave step backwards, since some hospitals have ceased to be facilities used by physicians for the treatment of their patients and have become facilities that offer physicians' services among other services. Much closer liaison needs to be maintained with the medical schools. Broad education needs to be a continuing process among all groups, using all modern communication facilities.

It appears very questionable as to whether or not physicians should have become involved in

prepaid medical insurance or in any form of insurance since this is a matter between the insuring agencies and the policyholders. It may have been far wiser for the medical profession to have taken the stand of the dental profession in this regard in saying it is not in the insurance business, when approached in regard to some suggestions on prepaid dental insurance. Certainly the medical profession has received the brunt of criticism for the marked rise in cost of drugs and cost of hospital care also. Would it not have been better to stand on the ancient principle of sliding-fee-for-service schedule rather than to see this relationship descend to that of a commodity price?

Tendencies in organized medicine are to follow the experiences of unions, and it is very doubtful if this policy will be as suitable for the medical profession as it has proved to be for the various

trades. We need a closer fellowship between all physicians, surgeons and general practitioners, and all specialties alike. All have common interests and problems, as well as common education and background. To bear in mind the principles of our ancient heritage and to remember that times may change but man does not, will go a long way toward restoring the equilibrium of our relationships with one another and with the laity.

To deny that a great part of medicine is already "socialized" is farcical. It serves no purpose to bury our heads in the sand like the fabled ostrich. We should realize, too, that no group is any more responsible for this trend than we are, and we should consider very carefully in which direction we are going.

DANIEL M. ADAMS, M.D.
PANAMA CITY

Laboratory Pitfalls

It does not matter if you need only a simple urinalysis or the use of complex tests, machines, computers and monitors with their additive circuits costing many thousands of dollars employed in the care of your patient, it is all useless unless the right test is ordered, is properly done, and its results understood and correctly used by you the physician. Chemicals and machines do not treat your patient. Wisely so, because they have neither heart nor judgment.

Any properly done test has several potential pitfalls, such as:

- (a) Not ordered.
- (b) Not needed.
- (c) Not correlated to the special condition of your patient (age, sex, disease or its

present stage, past or present treatment, et cetera).

- (d) Not repeated if at variance with clinical state.
- (e) Normal range for the test or for the laboratory performing it.
- (f) Inherent weakness of the test itself not known or taken into consideration.
- (g) Overconfidence of the physician in the test or its results.

Of course, improperly done tests will multiply pitfalls ad infinitum.

So treat the laboratory and other paramedical services as a needed friend. Never let their reports treat your patient.

CHARLES HALL DAFFIN, M.D.
PANAMA CITY



Now, now, Mrs. Forsythe, we've never lost a cold patient yet.

When she's experiencing acute discomfort from cold symptoms, it's small wonder the patient becomes distressed about her condition.

She will breathe easier when you prescribe Novahistine LP. Novahistine LP is a long-acting decongestant that helps restore normal mucus secretion and ciliary activity—physiologic mechanisms which prevent infection of the respiratory tract. A dose of two tablets taken in the morning and repeated in the evening will usually keep air passages clear for 24 hours.

Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention.

Caution patients who operate machinery or motor vehicles that drowsiness may result.

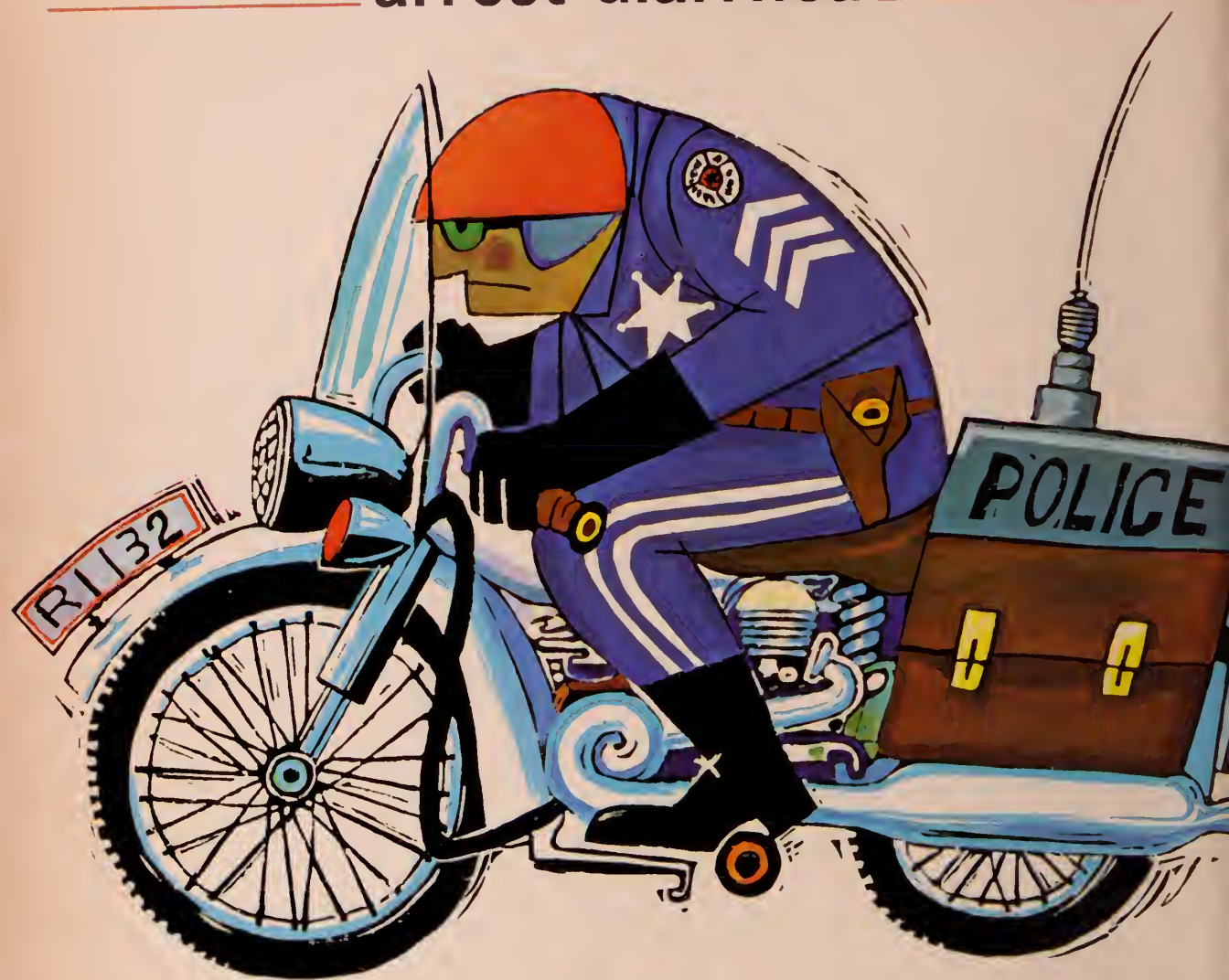
Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis 

NOVAHISTINE® LP

For relief of nasal congestion.

arrest diarrhea



LOMOTIL[®]

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride 2.5 mg.
(Warning: May be habit forming)
atropine sulfate 0.025 mg.







Effectiveness: Lomotil possesses a unique degree of effectiveness in both acute and chronic diarrhea.

Convenience: Lomotil is supplied as small, easily carried, easily swallowed tablets and as a pleasant, fruit-flavored liquid.

Versatility: The therapeutic efficiency, safety and convenience of Lomotil may be used to advantage alone or as adjunctive therapy in diarrhea associated with:

- Ulcerative colitis
- Acute infections
- Irritable bowel
- Regional enteritis
- Drug therapy
- Food Poisoning
- Functional hypermotility
- Malabsorption syndrome
- Ileostomy
- Gastroenteritis and colitis

Dosage: For correct therapeutic effect—Rx correct therapeutic dosage. The recommended initial daily dosages, given in divided doses, until diarrhea is controlled, are:

Children: Age	Total Daily Lomotil Dosage	Lomotil Liquid Dosage (Each teaspoonful [4 cc.] contains 2 mg. of diphenoxylate HCl)
3-6 months	3 mg. 	½ tsp. 3 times daily
6-12 months	4 mg. 	½ tsp. 4 times daily
1-2 years . . .	5 mg. 	½ tsp. 5 times daily
2-5 years . . .	6 mg. 	1 tsp. 3 times daily
5-8 years . . .	8 mg. 	1 tsp. 4 times daily
8-12 years	10 mg. 	1 tsp. 5 times daily

Adults: 20 mg. (2 tsp. 5 times daily or 2 tablets 4 times daily) Based on 4 cc. per teaspoonful. Maintenance dosage may be as low as one-fourth the initial daily dose.

Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is a Federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be kept out of reach of children since accidental overdosage may cause severe respiratory depression. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

SEARLE

Research in the Service of Medicine

Everyone says she's a barrel of fun



But what does she think?



Many overweight patients can benefit from the appetite control provided by the sustained anorexigenic-tranquilizing action of BAMADEX SEQUELS: anorexigenic action of amphetamine; tranquilizing action of meprobamate; prolonged action through sustained release of active ingredients.

Bamadex® Sequels®

DEXTRO-AMPHETAMINE SULFATE (15 mg.) SUSTAINED RELEASE CAPSULES
WITH MEPROBAMATE (300 mg.)

**to help establish
a new dietary pattern**

Contraindications: Dextro-amphetamine sulfate: in hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.



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A 'MAXIMUM SECURITY' ANTIBIOTIC*

* **THE BROAD RANGE DEPENDABILITY OF TETRACYCLINE**

long established as the broad-spectrum agent of first choice in a wide variety of infections

* **WITH THE ADDED SECURITY OF MEDIUM-SPECTRUM REINFORCEMENT**

triacytyloleandomycin is highly active against the common 'coccal' pathogens, including certain strains of staphylococci resistant to penicillin and tetracycline

* **ESPECIALLY VALUABLE IN U.R.I.**

provides decisive therapy in acute respiratory infections and other conditions in which staphylococci, streptococci or mixed flora are frequently encountered

* **NOW AVAILABLE IN NEW STRENGTH FOR NEW CONVENIENCE AND ECONOMY**

Signemycin 375 — high-potency capsules for simpler administration, greater patient economy

YMCIN[®] 375

(tetracycline 250 mg.
triacytyleandomycin 125 mg.)

Indications: Indicated in the therapy of acute severe infections caused by susceptible organisms and primarily by bacteria more sensitive to the combination than to either component alone. In any infection in which the patient can be expected to respond to a single antibiotic, the combination is not recommended. Signemycin should not be used where a bacteriologically more effective or less toxic agent is available. *Triacytyleandomycin*, a constituent of Signemycin, has been associated with deleterious changes in liver function. See precautions and adverse reactions.

Contraindications: Contraindicated in individuals who have shown hypersensitivity to any of its components. Not recommended for prophylaxis or in the management of infectious processes which may require more than 10 days of continuous therapy. If clinical judgement dictates therapy for longer periods, serial monitoring of liver function is recommended. Not recommended for subjects who have shown abnormal liver function tests, or hepatotoxic reactions to triacytyleandomycin.

Precautions and Adverse Reactions: *Triacytyleandomycin*, administered to adults in daily oral doses of 1.0 gm. for 10 or more days, may produce hepatic dysfunction and jaundice. Adults requiring 3 gm. of Signemycin initially should have liver function followed carefully and the dosage should be reduced as promptly as possible to the usual recommended range of 1.0 to 2.0 gm. per day. Present clinical experience indicates that the observed changes in liver

function are reversible after discontinuation of the drug.

Use with caution in lower than usual doses in cases with renal impairment to avoid accumulation of tetracycline and possible liver toxicity. If therapy is prolonged under such circumstances, tetracycline serum levels may be advisable. In long term therapy or with intensive treatment or in known or suspected renal dysfunction, periodic laboratory evaluation of the hematopoietic, renal and hepatic systems should be done. Formation of an apparently harmless calcium complex with tetracycline in any bone forming tissue may occur. Use of tetracycline during tooth development (3rd trimester of pregnancy, infancy and early childhood) may cause discoloration of the teeth. Reversible increased intracranial pressure due to an unknown mechanism has been observed occasionally in infants receiving tetracycline. Glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and definite allergic reactions occur rarely. Severe anaphylactoid reactions have been reported as due to triacytyleandomycin. Photosensitivity and photoallergic reactions (due to the tetracycline) occur rarely. Medication should be discontinued when evidence of significant adverse side effects or reaction is present. Patients should be carefully observed for evidence of overgrowth of nonsusceptible organisms including fungi, which occurs occasionally, and which indicates this drug should be discontinued and appropriate therapy instituted. Steps should be taken to avoid masking syphilis when treating gonorrhea.



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Science for the World's Well-being[®]
New York, N.Y. 10017



What does he drive home from work?

He drives the same kind of car he's been driving all day at the track — Porsche. A car driven by *people*, not push buttons.

He knows Porsche is a car *he* can control. The aircooled engine, of lightweight aluminium alloy, is in the rear for greater traction. It may be a midget by Detroit standards. But it powers the car, not gadgets.

Power is put into action by an improved 4-speed gear box (5-speed if you want it). Its smooth, even shifting action

makes it as automatic as he wants it to be. His profession demands a car that will hold the road. Porsche's safe, precise steering and torsion bar suspension keep him in command — at any speed, on any surface.

Even Porsche drivers have to stop sometime. So we use hydraulic disc brakes on all four wheels. Disc brakes resist overheating. They're virtually fade-free. And they outlast ordinary drum brakes by thousands of miles.

The new Porsche. It's an exciting car to drive. On the track.

Or on the way home.

Porsche


Porsche 911.6 cylinder engine, 148 horsepower, 5-speed synchromesh, (5-speed optional), top speed 130 mph.
Porsche 912.4 cylinder engine, 102 horsepower, 4-speed synchromesh, (5-speed optional), top speed 115 mph.

The Medical Detective



Masquerade by Inferno

Several years ago the sheriff of a county in the citrus belt was informed that a fire had consumed a shed in a grove which was used to store fuel. The fire burned for several hours during which time the sheriff inspected the scene. He received another call later in the day that a preliminary investigation of the ruins revealed a charred body.

A check of the grove workers showed that two young Negro men were missing and it was assumed that one of these was the victim. The sheriff sifted the ashes near the body and found a metal tube which was identified as the barrel of a single barreled shotgun. No shell could be found.

The sheriff discussed this case with the state attorney and it was decided that an autopsy should be performed. The body was sent to a neighboring city and a pathologist was asked to handle the case. His training included general and forensic pathology. The latter deals with the investigation of unnatural or suspicious deaths.

The first thing the pathologist did was to draw blood for carbon monoxide and for alcohol content. He had requested the radiology department of his hospital to x-ray the body and this examination was made promptly. The preliminary examination of the body revealed marked charring, contracted extremities with the arms in the "boxer" position and a fracture of the parietal region on the left side of the skull. The pathologist had a dentist friend make up an accurate detailed dental chart. The laboratory called and reported nega-

tive carbon monoxide and blood alcohol levels. The radiologists came down with wet films showing large numbers of shot in a tight pattern in the chest.

To have these facts before starting an autopsy is extremely important and helpful as it establishes that the victim was shot and not living during the fire. Thus a possible case of murder with an attempt to make it look like an accidental death was indicated.

The autopsy revealed massive destruction of the heart by a full charge of shot and the presence of wadding indicated that it was fired at close range. The lungs were free from carbon particles indicating further that the victim had not breathed during the fire. The skull fracture unaccompanied by evidence of bleeding suggested that it was the result of the extreme heat.

The sheriff's investigation established the identity of the victim through comparison of the victim's dental chart with that of one of the missing men. The missing grove worker was apprehended in a local night spot that evening and he readily confessed to his deed when he was asked to explain why his clothes reeked with fuel. The crime followed an argument over the affections of a popular local femme fatale.

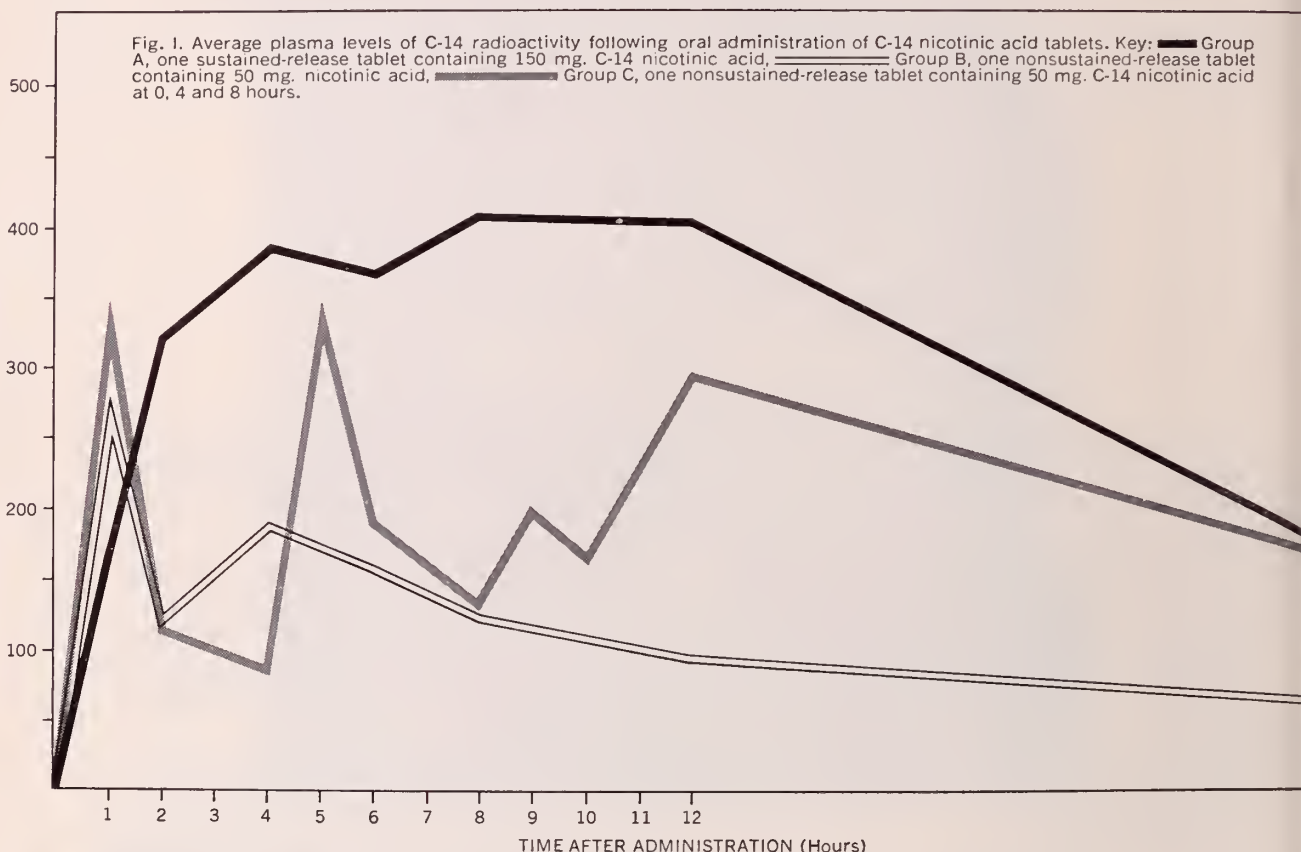
This is a good case to illustrate the many disciplines required to investigate a crime properly.

WILLIAM G. ECKERT, M.D.

Sustained circulatory, respiratory and cerebral stimulation for the

Fig. 1. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: — Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, — Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, — Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

C-14 AS MICROGRAMS NICOTINIC ACID PER LITER OF PLASMA



(fewer absent doses by
absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-

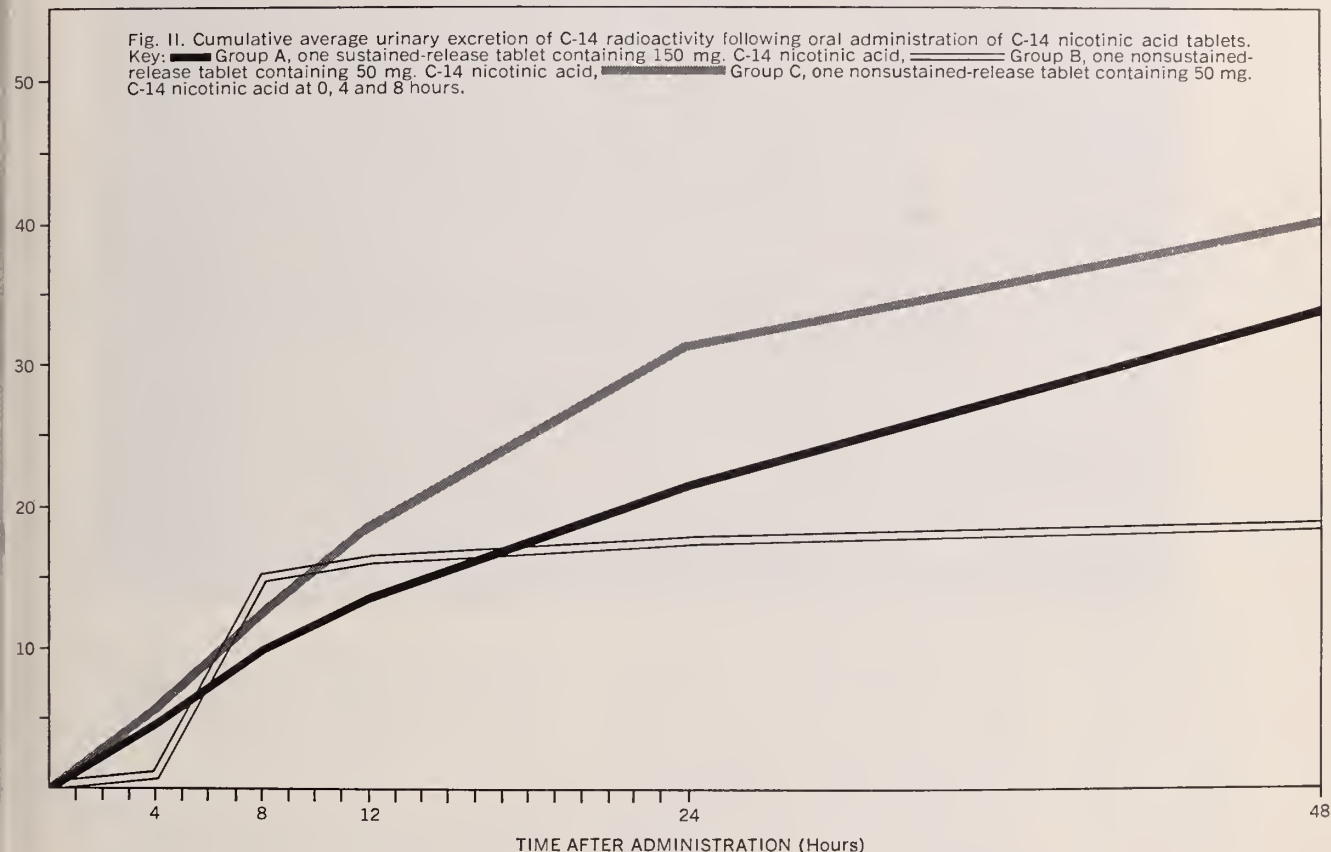
mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilation needed in patients with deficient circulation with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylentetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate signs of senile confusion. Patients become more alert

ged and debilitated

Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: — Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, — Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, — Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.



ss confused and moody. Personal care, memory, notional stability, social attention improve. Fatigue, bathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. 56:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. 11:617 (July) 1960.

"First with the Retro-Steroids"
PHILIPS ROXANE LABORATORIES
 Division of Philips Roxane, Inc., Columbus, Ohio
 A Subsidiary of Philips Electronics and
 Pharmaceutical Industries Corp.

Geroniazol[®] TT

nicotinic acid 150 mg., pentylenetetrazol 300 mg.
 Tempotrol[®] Time Controlled Tablet



Equip your ICU with the exact monitoring capabilities you need

You can have a system "tailored" to your needs — using standard HP Sanborn monitoring modules — whether it involves a few conditions for a few patients . . . or many patient conditions, eight or more beds, and complete central station alarm/display/recording facilities. Start with 780-series modules for monitoring the ECG and heart rate, for example (shown above), and as needs and budget enlarge, add "780" modules to monitor more functions, more patients or both. (Illustration below shows the addition of temperature, respiration rate, systolic and diastolic pressure monitoring functions, plus pacemaker, to the original two functions.) System suitability, economy, future functional and location adaptability, and rapid staff training are the continuing benefits of modular "780" systems.

Specific capabilities of these units, in addition to those mentioned, include venous pressure monitoring . . . internal/external DC defibrillation . . . and continuous ECG recording on endless loop magnetic tape units, with automatic read-out on alarm of data immediately preceding distress condition. Wall Mount Brackets are avail-

able to free space around beds, or two styles of "780" carts give complete instrumentation mobility. For Central Station use, a wide choice of units is available for visual display, audible alarm, signal switching, graphic and tape recording.

When complete cardiac function monitoring is needed, with automatic ECG recording at selected intervals or on distress, the 780B Viso-Monitor provides it in a single bedside unit. Indicators display heart rate, QRS event, bradycardia, tachycardia, pulse loss and arrest; internal/external pacemaker is built in. Companion unit supplies visual display and audible alarm of all conditions monitored by the Viso-Monitor.

HP/Sanborn field offices can give you valuable help in system planning, installation and staff training — and provide continuing, local service. For details, send the coupon to Hewlett-Packard Company, Sanborn Division, Waltham, Mass. 02154. In Europe, H.P.S.A., 54 Route des Acacias, Geneva.



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NEWS

AMA To Hold Clinical Convention

A scientific program designed particularly for the physician in private practice is scheduled for the 20th Clinical Convention of the American Medical Association.

The four-day meeting in Las Vegas Nov. 27-30 will include scientific sessions on 18 major topics, three postgraduate courses, breakfast roundtable conferences, closed-circuit television and medical motion picture programs and a variety of scientific exhibits.

The postgraduate courses have been expanded to three topics: Obstetrics and Gynecology, Fluid and Electrolyte Balance and Cardiovascular Disease. Each course will consist of three half-day sessions, each of which will feature several outstanding teachers. There will be a \$10 registration fee for each course.

New Drug Introduction Lowest in 25 Years

National introductions of new medicines by American drug companies declined sharply during the first six months of 1966 to the lowest point in 25 years, according to Paul de Haen, Inc., Drug Information Services.

Thirty-nine new products were introduced, compared with 55 for the first half of 1965 and 154 for the same period five years ago. New drug products are defined as single chemical entities, duplicates of existing products and new combinations of existing products.

The sharpest decline was in the number of single new chemicals. Only four were approved for marketing by the U. S. Food and Drug Administration during the first half of this year, compared with 14 during the same period a year ago and 24 in the same period five years ago.

FMA Member Lectures at NYU

FMA member Dr. Harvey Blank, professor and chairman of the Department of Dermatology, University of Miami School of Medicine, will deliver the 14th annual Sigmund Politzer Lecture at the New York University Medical Center, November 15, 1966.

Dr. Blank's topic will be "Virus, Cell and Host Relationships in Varicella-Zoster Infections." The lecture will be given at 8:45 p.m. in Classroom B of Alumni Hall, 550 First Avenue, New York, N. Y.

Southeastern Internists Hold Scientific Meeting

The American College of Physicians will hold a scientific meeting for internal medicine specialists in its Southeastern Region on October 7-8 at the Buena Vista Hotel-Motel in Biloxi, Mississippi. The meeting will be held for doctors in Alabama, Florida, Georgia, Louisiana, Mississippi and South Carolina.

The regional meeting is one of 30 scientific sessions sponsored each year by the ACP throughout the United States and Canada and in the Far East. It serves to help keep College members abreast of developments in the basic sciences and clinical medicine. The ACP represents some 13,000 specialists in internal medicine and related fields.

Irving S. Wright, M.D., New York, N.Y., ACP president and professor of clinical medicine at Cornell University Medical College, will be a special guest.

The meeting is under the general direction of a committee of governors with Wesley W. Lake, Sr., M.D., of Pass Christian, Miss., ACP governor for Mississippi and associate in medicine at Tulane University School of Medicine, as host governor.

St. Francis Hospital Seminar
Carillon Hotel, Miami Beach, Fla.
October 27-29, 1966

**"WHAT'S NEW IN GERIATRIC
MEDICINE AND SURGERY"**

George C. Griffith, M.D., Emeritus Pro-
fessor of Medicine, University of
California

1. Coronary Artery Disease
2. Congestive Heart Failure
3. Cerebrovascular Disease, Its Early
Recognition and Treatment

Samuel R. Powers, Jr., M.D., Professor
of Surgery, Albany Medical College

1. Prevention and Evaluation of
Acute and Chronic Renal Failure
2. Management of Acute and
Chronic Renal Failure

Sidney E. Ziffren, M.D., Professor of
Surgery, University of Iowa

1. Special Problems in Surgery of
the Aged
2. Intestinal Obstruction in the Aged
3. "Pulling Punches" in Surgery of
the Aged

PANELS

1. General Surgery in Patients with
Recent Myocardial Infarction
2. Pulmonary Embolism
3. Burns
4. Surgical and Medical Shock
5. Queries and Answers

SESSIONS

Thursday, Oct. 27: 2-5 and 8-10 p.m.
Friday, Oct. 28: 2-5 and 8-10 p.m.
Saturday, Oct. 29: 10 a.m. - 1 p.m.

For additional information: Contact
Seminar Office, St. Francis Hospital,
Miami Beach, Florida
Telephone: UN 6-1411

**UF Receives \$117,899
Heart Research Grant**

The University of Florida's College of Medicine has received a research grant of \$117,899 from the John A. Hartford Foundation, Inc., New York City, for studies of the ultra-structure of the muscular wall of the heart in which the inside of cells are magnified from 1,000 to 500,000 times.

The award, which is for a three-year period, was announced jointly by Ralph W. Burger, foundation president, and Dr. Emanuel Suter, dean of the college.

Dr. Myron W. Wheat Jr., director of the project, said the studies are a continuation of earlier investigations also supported by the Hartford Foundation.

The new fund will make possible additional effort in evaluating the various procedures used in open heart surgery by probes into the subcellular structure of diseased hearts subjected to heart by-pass techniques and studies to clarify the role of the lysosome in human heart tissue.

**American Cancer Society
Holds Scientific Session**

The 1967 scientific session of the American Cancer Society is to be held May 3 at the Sheraton-Dallas Hotel, Dallas, Texas.

This symposium on "Current Concepts in Etiology and Diagnosis of Cancer" is open to all members and students of the medical professions. There is no advance registration or registration fee.

FMA Member Completes Voluntary HOPE Tour

Dr. Leo Conn, Miami, completed July 15 a voluntary two-month tour of service aboard the S.S. HOPE, the hospital ship now on a teaching-treatment mission to Nicaragua.

Dr. Conn, a surgical specialist, is a graduate of Long Island University and received his medical degree from the University of Utrecht, the Netherlands. Currently in private practice, he is affiliated with St. Francis and Mt. Sinai Hospitals, both in Miami Beach.

3 UF Physicians Granted Awards

Three young physicians in the University of Florida's College of Medicine were recipients of Research Career Development awards from the National Institute of Health.

The awards were granted to the UF on behalf of Dr. Daniel Belkin, Instructor in physiology; Dr. Hiram Kitchen, assistant professor in the departments of medicine and biochemistry; and Dr. Nikaan Andersen, assistant professor of anesthesiology.

THE DUVALL HOME for RETARDED CHILDREN

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Medicare Advisory Group Appointed

An 11 member group representing the insurance organizations which serve as intermediaries in the payment of physicians' bills under the medicare program was named recently by Arthur E. Hess, Director of the Social Security Administration, Bureau of Health Insurance.

The group will provide consultation to the Social Security Administration on the impact of proposed regulations and operating instructions affecting the administrative responsibilities of the medical insurance intermediaries. Hess noted that consultation with representatives of organizations involved in the administration of medicare contributed substantially to the advance planning that assured the program's smooth start on July 1. "Now that the program is actually running," he said, "it is even more important to have a means of getting the concerted and representative judgments of the intermediaries on ways to improve procedures, policies, and relationships."

Members of the advisory group are: Dr. Carl Ackerman, member of the board, United Medical Service, Inc. of New York; A. E. Halverson, vice president of Occidental Life Insurance Company of California; R. J. Jones, vice president of Pilot Life Insurance Company; Denwood Kelly, execu-

tive director of Maryland Medical Services, Inc.; John McCabe, executive director of Michigan Medical Service; Dr. George Melcher Jr., president of Group Health Insurance, Inc., New York; Morton D. Miller, vice president of Equitable Life Assurance Society; Daniel Pettengill, vice president of Aetna Life Insurance Company; Jack Vance, executive vice president of Colorado Medical Services, Inc.; Joseph Vance, vice president of Blue Cross-Blue Shield of Alabama, and William White Jr., director of health insurance relations, Prudential Insurance Company of America.

Under the medical insurance program, 33 Blue Shield plans, 15 commercial insurance organizations and one independent insurer perform a number of administrative functions under contracts with the federal government.

The intermediary's principal responsibility is to determine "reasonable charges" for physicians' services and to make payment on that basis. It also acts as a channel of communication with the medical and health professions.

In determining reasonable charges, an intermediary considers the usual and customary charge made by the physician as well as the prevailing

rates in the area for similar services. In making payment, it must also assure that the charges it pays for medicare patients are no higher than it pays for comparable services and under comparable circumstances for its own policyholders or subscribers.

Intermediaries are responsible for applying safeguards against unnecessary utilization of covered services and are required to maintain such records and furnish such information as the government finds necessary.

Infectious Syphilis Continues To Increase

In 1965, reported cases of primary and secondary syphilis (infectious stages) increased 1.6 per cent in the United States, from 22,969 cases in 1964 to 23,338 cases in 1965, according to recent statistics from the Public Health Service, Department of Health, Education, and Welfare.

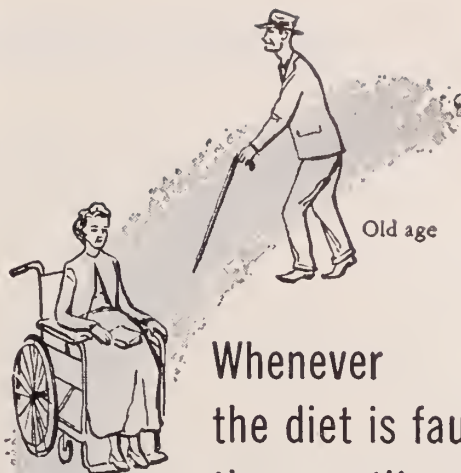
In Florida, the number of cases reported has increased from 2,004 in 1964 to 2,356 in 1965 and the rate per 100,000 population has jumped from 35.7 in 1964 to 41.2 in 1965.

The Public Health Service urges caution in interpreting state and city syphilis morbidity figures. According to PHS, increasing primary and secondary syphilis morbidity in any given area may mean some or all of the following:

1. Syphilis incidence is increasing.
2. The finding and identifying of cases in their earliest stages has been intensified.
3. Private physicians are reporting a greater proportion of the cases which they diagnose.

On the other hand, PHS points out that decreasing morbidity in any given area may mean some or all of the following:

1. Syphilis incidence is decreasing.
2. Casefinding has become less effective.
3. Fewer diagnosed cases are being reported.



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Convalescence



Adolescence



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Typhoid Vaccination No Longer Needed

The Public Health Service Advisory Committee on Immunization has concluded that routine typhoid fever vaccination is no longer needed in the United States.

Surgeon General William H. Stewart accepted the findings of the committee and stated as PHS policy that immunization against the disease is not recommended on a routine basis.

The committee reported that the incidence of typhoid in this country has declined steadily for many years and is now less than 500 cases per year. A continuance of the downward trend was predicted.

"Cases are sporadic and are primarily related to contact with carriers rather than to common source exposure," the committee stated. "Recognizing this epidemiologic pattern of typhoid fever,

redefinition of the role and use of typhoid vaccine is indicated."

The committee further commented that, "although typhoid vaccine has been suggested for individuals attending summer camps and those in areas where flooding has occurred, there are no data to support the continuation of these practices."

Select immunization, however, was recommended in the following situations:

1. Intimate exposure to a known typhoid carrier as would occur with continued household contact.
2. Community or institutional outbreaks of typhoid fever.
3. Foreign travel to areas where typhoid fever is endemic.

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DOSAGE: One capsule t.i.d. or as prescribed by physician.

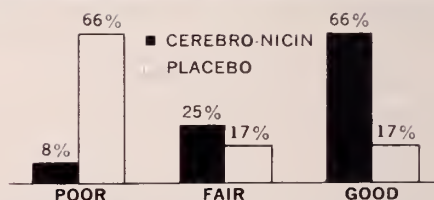
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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jnl. of the Amer. Ger. Soc., June, 1964.

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Letters

August 3, 1966

Dear Editor:

There is an error in the article "An Assessment of Gastric Analysis" published in the October 1965 issue of the Journal of the Florida Medical Association, volume 52, number 10, page 714.

It is not necessary to multiply by a factor of 10 to change the number of cc. of 0.1N NaOH required to neutralize 100 cc. gastric juice since this number is equal to mEq/L. The example given is also incorrect. The correct answer is 5 mEq/L. Reference: Gradwohl's Clinical Laboratory Methods and Diagnosis, Vol. II, 1963. P. 1,914.

Gastric Analysis

Terminology

$$\text{Equivalent (eq.)} = \frac{\text{gram molecular weight}}{\text{valence}}$$

$$1 \text{ Normal (N)} = 1 \text{ equivalent in 1,000 cc. solution}$$

$$1 \text{ Milliequivalent (mEq.)} = \frac{1 \text{ equivalent}}{1,000}$$

$$\text{Clinical units (c.u.)} = \text{degrees} = \text{number cc. of 0.1N NaOH to neutralize 100 cc. gastric solution}$$

$$\text{Clinical units also} = \text{mEq/L (Reference: Gradwohl's Clinical Laboratory Methods and Diagnosis, Vol. II, 1963, P. 1,914)}$$

$$1,000 \text{ cc. of a 1N solution contains 1 eq.}$$

$$1 \text{ cc. of a 1N solution contains .001 eq. or 1 mEq.}$$

$$1 \text{ cc. of a 0.1N solution contains .1 mEq.}$$

Proper way to solve problem in article:

After finding the number of cc. of .1N NaOH to neutralize 100 cc. gastric juice (clinical units) it is NOT necessary to multiply by 10 as the article states because clinical units are = to mEq/L. In this problem the number of cc. = 5 (5 mEq/L).

Figuring another way: 5 cc. of .1N NaOH contains 0.5 mEq. of NaOH. Since this amount was

necessary to neutralize 100 cc. solution it would take 5 mEq. to neutralize 1,000 cc. 5 mEq/L is the correct answer to the problem.

Examples taken from Cecil-Loeb Textbook of Medicine, Vol. I, 1963, P. 894.

12 Hour Nocturnal Gastric Secretion (Comparative Average Values)

	Vol. cc.	c.u.	mEq.
Normal	581	29	18
Gastric ulcer	600	21	12.5
Duodenal ulcer	1,004	61	62

In summary:

mEq/L is a measure of CONCENTRATION
mEq. is a measure of AMOUNT

If the doctor is told the number of mEq. required to neutralize 100 cc. gastric solution, then it IS necessary to multiply by a factor of 10 to arrive at mEq/L.

BUT, if the doctor is told the number of cc. of .1N NaOH (Clinical units) to neutralize 100 cc. gastric solution, it is NOT necessary to multiply by a factor of 10 as stated in the article because each cc. of .1N NaOH contains .1 mEq. and since you want to know how many mEq. needed to neutralize 1,000 cc. of solution you DO NOT have to multiply by 10 because you are working with .1 mEq. and not mEq.

ROBERT E. DUNCAN, M.D.
GENERAL SURGICAL RESIDENT
DUVAL MEDICAL CENTER
JACKSONVILLE

August 15, 1966

Robert E. Duncan, M.D.
Department of Surgery
Duval Medical Center
Jacksonville, Florida

Dear Dr. Duncan:

Thank you for your discerning analysis of my article, "An Assessment of Gastric Analysis" which appeared in the Journal of the Florida Medical Association 52:714, 1965. You are certainly correct both in turning up the error and in your explanations for its incorrectness. The factor of 10 should have been applied to the number of milliequivalents determined by titration and not

to the number of milliliters required in the titration process.

I think you will be interested to know that titration methods employing indicators or titration to a pH end-point may well soon be replaced by the use of the glass electrode. The latter allows a reasonably accurate assessment of the pH of a gastric juice sample; the pH determined is really a measurement of hydrogen ion activity (aH^+) i.e., the activity of ionized hydrogen ions) and does not take into consideration the hydrogen ions bound in the form of weak acids and to mucus (these ions add to the total acid when titration with NaOH is employed). The work of Moore and Scarlatta (Gastroenterology 49:178, 1965) explains the calculation of hydrogen ion concentration from electrode determined pH values of hydrogen ion activity. The hydrogen ion concen-

tration (aH^+) is always slightly higher than the hydrogen ion activity (aH^+) and varies with the concentration of sodium and potassium ions in mEq/L. I imagine that the table of conversions will be published soon. The technique of calculating acid output has been considerably simplified by this technique; standard outputs of acid secretion in various disease states will have to be revised, however, as the acid outputs are uniformly lower by this technique.

Thank you again for pointing out my error both to me and the readers of the Journal.

ARVEY I. ROGERS, M.D.

CHIEF, GASTROENTEROLOGY

VETERANS ADMINISTRATION HOSPITAL

CORAL GABLES

September 8, 1966

Dear Editor:

My first reaction to the editorial entitled "No Saskatchewan in Florida," by Dr. John J. McAndrew of Orlando, in the September issue of the Journal was that somehow and in some way the officers and committee members have not been able to convince many of the rank and file membership of the FMA that recently enacted federal health legislation is a milestone in the history of this nation and will involve all physicians in their private practice of medicine. I have mentally reviewed many of the actions of our elected FMA officials who have tried to represent organized medicine to our Washington representatives, and I do not see how we could have done otherwise under the conditions.

If our leaders in organized medicine have had a higher "anxiety level" than their individual members, it is because they can clearly see the trend of legislation written in Washington and the profound effect upon medicine and society that will result. It seems to me there is an important fork in the road just ahead for organized medi-

cine; it can address itself to the full scope of its true professional role in the new America that is now taking shape, or it can simply become a trade association to protect the interests of a group of technical specialists in a technological society. I think that organized medicine has and will assume the first role. We should and must direct and assist our federal government in its attempt to meet the demands of the day to day application of scientific progress and realize the principle of equality will be gradually developed for all.

Medicine is thus thrust into a place close to the heart and philosophy of our American system. If at times we do seem anxious, it is the same kind of concern that we show for people who are ill, because we know better than anyone else the results of neglect. This action in no way can and should detract from the physician's primary dedication to the welfare of the patient.

FLOYD K. HURT, M.D.

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Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions: Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

If a reaction or overgrowth of nonsusceptible organisms occurs, withdraw the drug.

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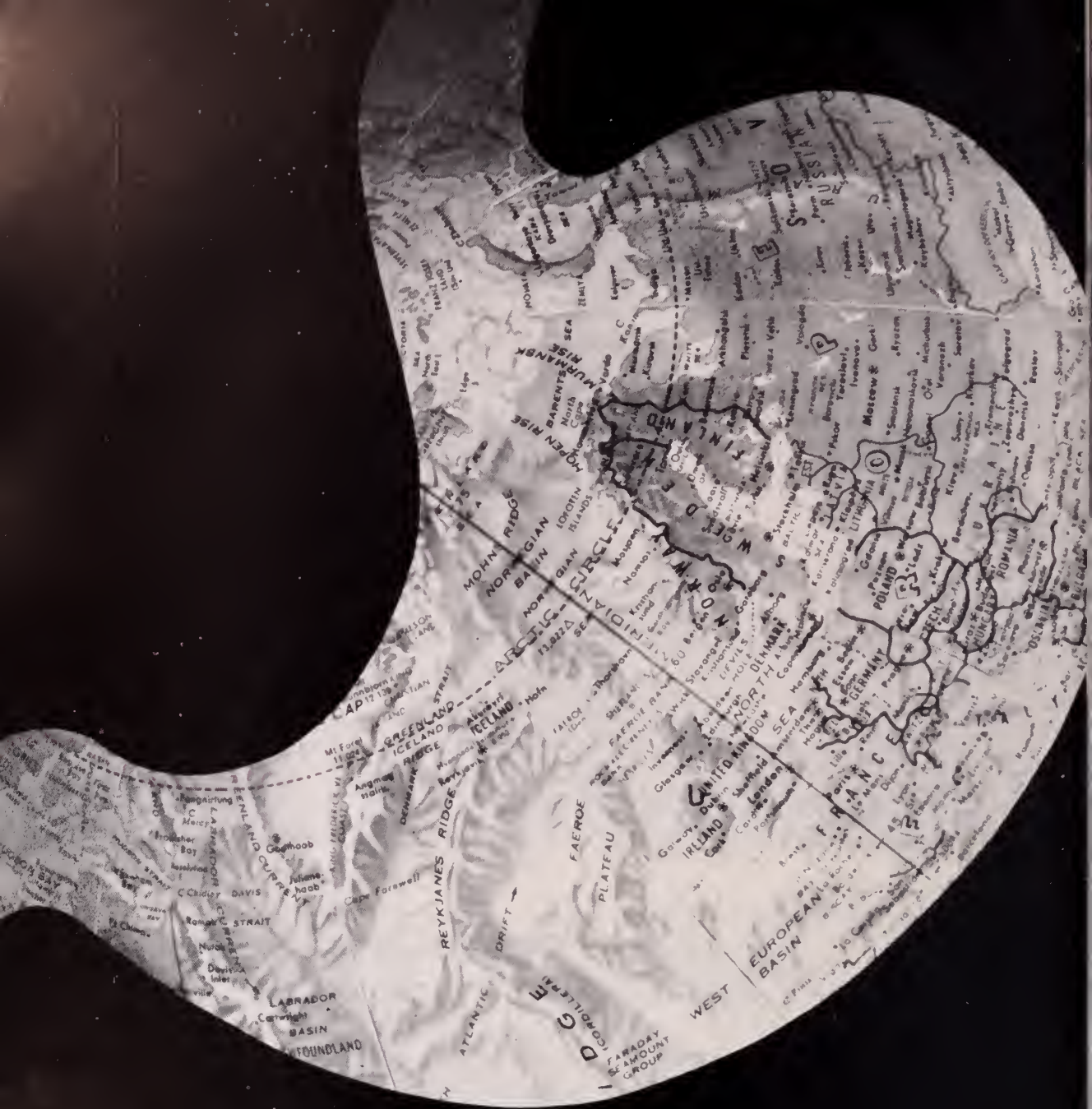
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The “Socio-geographic” mystery

Why is one man's gastric ulcer another man's duodenal?



Geographic variation in the *incidence* of peptic ulcer is a familiar fact. But the proclivity of certain *kinds* of ulcer for certain geographic areas is a recently recognized phenomenon.^{1,2}

For example, in one particular Norwegian fishing village there is a tendency for patients to develop a gastric ulcer; anywhere else in Norway, ulcers are usually duodenal. Peruvians high in the Andes have more gastric ulcers than their compatriots in the lowlands. Why? Nobody knows.

Social variations, too. Even in the same geographic areas there are interesting variations. An Englishman's ulcer depends on his social standing—professional men suffer with duodenal ulcers, while workingmen have more of the gastric variety. In southern India the pattern is reversed. Here, duodenal ulcers are common among laborers and agricultural workers and rare among the upper classes.

Investigators are exploring every possible theoretical avenue in their search for the cause of peptic ulcer. Of all the factors implicated in ulcerogenesis, the one that is generally acknowledged to be of primary importance is hypersecretion of gastric acid.³⁻⁸ Or, as one author states it: "The medical management of peptic ulcer pharmacologically is, in the final analysis, concerned largely with the effective inhibition of peptic activity."³

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(brief summary follows)

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Precautions: Administer with caution in the presence of incipient glaucoma.

Adverse Reactions: Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

Dosage: Dosage should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet 3 times a day: in the a.m., early p.m., and at bedtime. *See product literature for full prescribing information.*

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References: 1. Jones, F. A., and Gummer, J. W. P.: Clinical gastroenterology, Springfield, Ill., Charles C Thomas, 1960, pp. 322-3. 2. Bockus, H. L.: Gastroenterology, 2nd ed., vol. I, Philadelphia, Saunders, 1963, p. 468. 3. Sun, D. C. H.: Ann NY Acad Sci 99:153 (Feb. 28) 1962. 4. Moore, V. A.: Postgrad Med 38:216 (Sept.) 1965. 5. Dragstedt, L. R., Woodward, E. R., Storer, E. H., Oberhelman, H. A., Jr., and Smith, C. A.: Ann Surg 132:626 (Oct.) 1950. 6. Posey, E. L., Jr., Smith, P., Turner, C., and Aldridge, J.: Amer J Dig Dis 10:399 (May) 1965. 7. Lamphier, T. A., Siegel, L., and Goldberg, R. I.: Amer J Gastroent 37:551 (May) 1962. 8. Kasich, A. M., and Fein, H. D.: Ibid 39:61 (Jan.) 1963. 9. Epstein, J. H.: Ibid 37:295 (Mar.) 1962. 10. Moeller, H. C.: Ann NY Acad Sci 99:158 (Feb. 28) 1962. 11. Slinger, A.: J New Drugs 2:215 (Jul.-Aug.) 1962. 12. Barman, M. L., and Larson, R. K.: Amer J Med Sci 246:325 (Sept.) 1963. 13. Shutkin, M. W.: Amer J Gastroent 38:682 (Dec.) 1962. 14. Fleshler, B.: J New Drugs 2:211 (Jul.-Aug.) 1962. **A. H. ROBINS CO., INC.**
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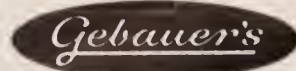
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The following is a brief precautionary statement. Before prescribing, the physician should be familiar with the complete prescribing information in SK&F literature or *PDR*.

Precautions: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Do not use in patients taking MAO inhibitors. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence; in these instances, withdraw the medication. Use cautiously in pregnant patients, especially in the first trimester. *Side effects:* Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.



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drowsiness and patients should not perform tasks requiring mental alertness while taking this agent. Bacterial or mycotic superinfection may occur. Infants may develop increased intracranial pressure with bulging fontanelles. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for three months. **Adverse Reactions:** Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis and allergic reactions may occur. **Usual Adult Dose:** Two capsules q.i.d. Continue therapy for at least 10 days in beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals.

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Syracuse, New York



"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

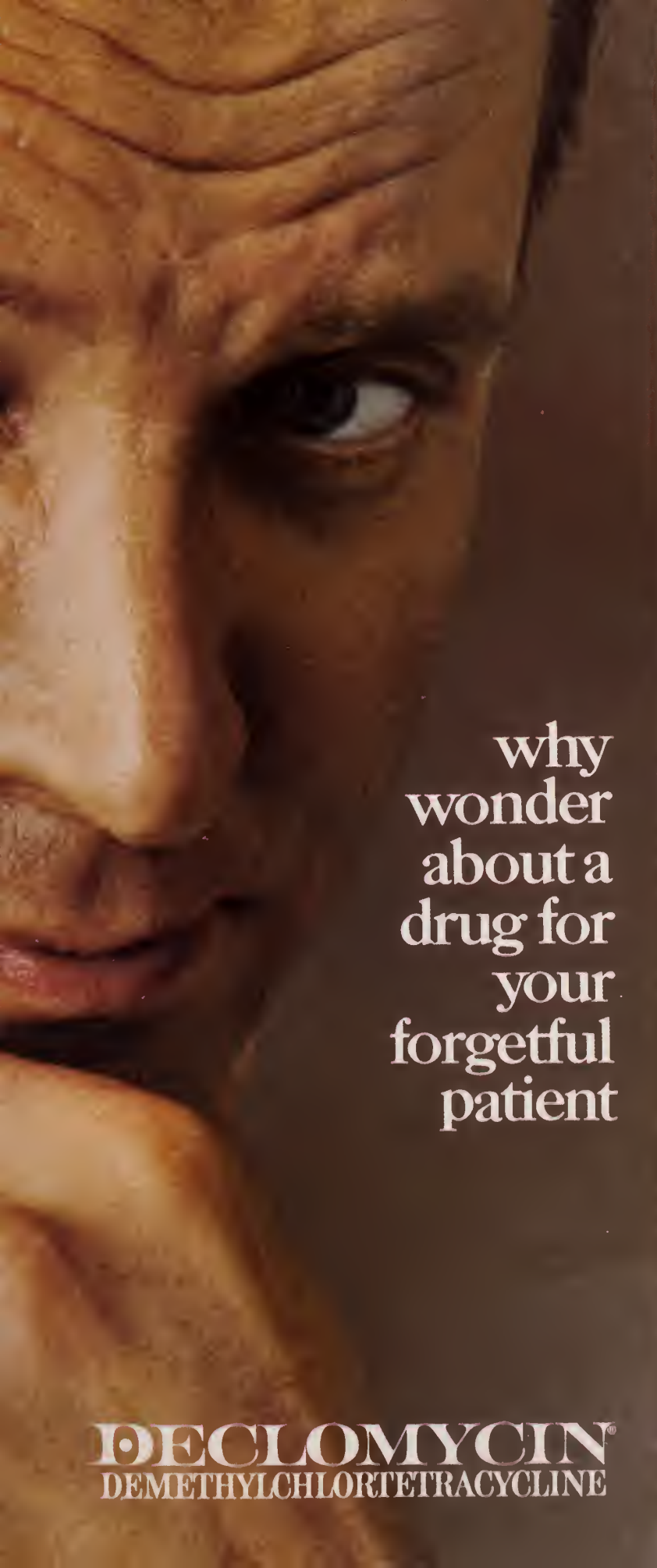
Bayer's standards are far more demanding. In fact, there are at least *nine specific differences in-*

volving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to stay strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.





why
wonder
about a
drug for
your
forgetful
patient

DECLOMYCIN[®]
DEMETHYLCHLORTETRACYCLINE

doses between 2.5 and 10 mg., which is a 200 to 1 ratio as compared to chlorothiazide..."¹³

Moreover, due probably to its virtual lack of carbonic anhydrase inhibition, Naturetin (bendroflumethiazide) has been shown to cause less potassium and bicarbonate loss and less alteration in urinary pH than either chlorothiazide or hydrochlorothiazide.

Naturetin is outstandingly effective not only in establishing, but also in maintaining, excretion of retained fluid in edematous patients. And its duration of action is sufficiently prolonged to allow a single daily administration in most patients. Naturetin is also an effective antihypertensive agent.

Contraindications: Severe renal impairment; previous hypersensitivity.

Warning: Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting, or G.I. bleeding occur.

Precautions: The dosage of ganglionic blocking agents, veratrum, or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Electrolyte disturbances are possible in cirrhotic or digitalized patients.

Side Effects: Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, and rashes may occur.

Supplied: Naturetin (Squibb Bendroflumethiazide) 5 mg. and 2.5 mg. tablets. Also available Naturetin \bar{c} K [Squibb Bendroflumethiazide (5 or 2.5 mg.) with Potassium Chloride (500 mg.)]. For full information, see Product Brief.

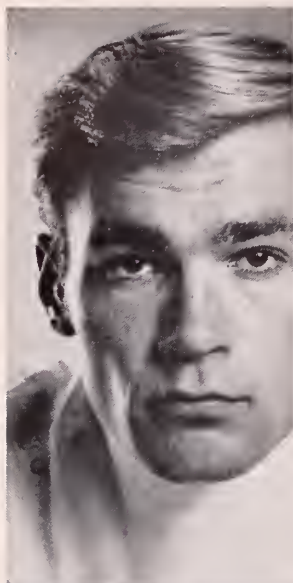
References: 1. Southworth, H.: *Proc. Soc. Exper. Biol. & Med.* 36:58, 1937. 2. Mann, T. and Keilin, D.: *Nature* 146:164, 1940. 3. Pitts, R. F., and Alexander, R. S.: *Am. J. Physiol.* 144:239, 1945. 4. Schwartz, W. B.: *New England J. Med.* 240:173, 1949. 5. Friedberg, C. K., in Moyer, J. H., and Fuchs, M.: *Edema Mechanisms and Management*, Philadelphia, W. B. Saunders Co., 1960, p. 259. 6. Cumming, J. R.; Tabachnick, E., and Seelig, M., in Moyer, J. H., and Fuchs, M.: *op. cit.*, p. 254. 7. Werko, L., in Moyer, J. H., and Fuchs, M.: *op. cit.*, p. 188. 8. Beyer, K. H., Jr., in Moyer, J. H., and Fuchs, M.: *op. cit.*, p. 274. 9. Maren, T. H., and Wiley, C. E.: *J. Pharmacol. & Exper. Therap.* 143:230, 1964. 10. Earley, L. E., and Orloff, J.: *Ann. Rev. Med.* 15:149, 1964. 11. Fuchs, M., and Mallin, S. R., in Moyer, J. H., and Fuchs, M.: *op. cit.*, p. 276. 12. Ford, R. V., in Moyer, J. H., and Fuchs, M.: *op. cit.*, p. 290. 13. cited in Fuchs, M., and Mallin, S. R. (ref. 11): *op. cit.*, p. 283.

Naturetin[®]

SQUIBB BENDROFLUMETHIAZIDE
to reduce excess fluid
or high blood pressure



"The Priceless Ingredient" of every product
is the honor and integrity of its maker



-more convenient
-more easily
remembered

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE
300 mg FILM COATED TABLETS
are made for b.i.d.

Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive.

Contraindication—History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort.

Precautions and Side Effects—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

Capsules: 150 mg; Tablets: film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

It stands to reason. They training; they all have to all have to measure up to all are underpaid, too. T alike.

That's utter nonsense more nonsensical than about aspirin. Namely: si supposed to come up to ards, then all aspirin table

Bayer's standards are fact, there are at least nin

MOLECULAR REMODELING—

laboratory exercise or clinical necessity?

More than twenty-five years have passed since the discovery of the diuretic activity of sulfanilamide started pharmacologists on a succession of molecular remodelings to find the ideal diuretic.

Diuresis—a sought-after clinical effect from an unwanted side effect

It started in 1937 when a clinician reported that the administration of a sulfonamide was sometimes accompanied by an unexplainable side effect—metabolic acidosis.¹ Three years later the side effect was explained. The sulfonamide radical of sulfanilamide inhibited carbonic anhydrase,² the enzyme responsible for converting carbon dioxide and water to hydrogen ions and bicarbonate ions.

Later, other investigators showed by dog experiments that metabolic acidosis probably resulted when the inhibition of carbonic anhydrase upset the exchange of hydrogen and sodium ions, causing increased excretion of sodium as the bicarbonate.³

It was twelve long years after the first report of the unexplainable side effect (metabolic acidosis) that it was finally shown that large doses of sulfanilamide administered to edematous patients were indeed capable of promoting diuresis.⁴ However, the possibility of toxic effects from its prolonged use and its relatively weak diuretic action made it impractical for clinical use as a diuretic.⁵

Because the inhibition of carbonic anhydrase seemed to be the key to effective diuresis, investigators began to look for more potent enzyme inhibitors—in the hopes that they would be more effective diuretics.

The most important of these early compounds, acetazolamide, enjoyed several years of fairly wide clinical use.

Its carbonic anhydrase inhibitory activity was several hundred times greater than that of sulfanilamide.⁶ The increase in inhibitory activity, however, increased not only the excretion of sodium and bicarbonate ions, but also the excretion of potassium.⁷ And, like its predecessor, acetazolamide precipitated mild acidosis. Its prolonged use could result in hypokalemic acidosis.⁷

The 'thiazides'—an answer to the metabolic acidosis caused by carbonic anhydrase inhibition

Despite the fact that the sulfonamide

group appeared to be responsible for carbonic anhydrase inhibition which in turn appeared to be responsible for diuresis, investigators began to synthesize compounds with structural alterations to the sulfonamide group.

The first major breakthrough came with the synthesis of chlorothiazide. Altering the sulfonamide group did indeed alter the ability of chlorothiazide to inhibit carbonic anhydrase—it was only 1/10th as potent as acetazolamide in inhibiting the enzyme.⁸ Despite the drop in inhibitory potency, however, chlorothiazide proved to be an effective diuretic—an observation that led to the conclusion that its diuretic action was due to some mechanism other than its action on carbonic anhydrase.^{9,10}

For effective diuresis, chlorothiazide was administered in daily dosages ranging from 250 to 2000 mg.¹¹ It increased the excretion of sodium and chloride; and, to a lesser extent, potassium and bicarbonate.¹¹ The excretion of potassium appeared to be maximal at higher dose levels at which, theoretically, the carbonic anhydrase inhibitory effect is more active.¹¹ Its prolonged use, therefore, could sometimes result in metabolic hypokalemic, hypochloremic alkalosis.⁷

Naturetin—effective diuresis with more favorable electrolyte balance

Other thiazides followed—with improvements being aimed at two particular areas: 1. attempts to increase diuretic action in relation to the milligram potency of the drug, and 2. attempts at a more favorable sodium/potassium ratio in the urine, i.e., to decrease the excretion of potassium while maintaining the excretion of sodium.¹²

One of these, Naturetin, Squibb Bendroflumethiazide, has made advances on both these points. "By adding a 3-benzyl radical to hydroflumethiazide a rather dramatic reduction in dose range is accomplished. With this drug, effective sodium excretion is obtained with

doses between 2.5 and 10 mg., which is a 200 to 1 ratio as compared to chlorothiazide..."¹³

Moreover, due probably to its virtual lack of carbonic anhydrase inhibition, Naturetin (bendroflumethiazide) has been shown to cause less potassium and bicarbonate loss and less alteration in urinary pH than either chlorothiazide or hydrochlorothiazide.

Naturetin is outstandingly effective not only in establishing, but also in maintaining, excretion of retained fluid in edematous patients. And its duration of action is sufficiently prolonged to allow a single daily administration in most patients. Naturetin is also an effective antihypertensive agent.

Contraindications: Severe renal impairment; previous hypersensitivity.

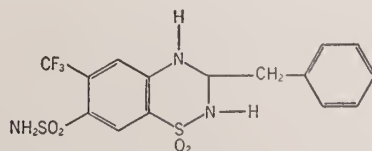
Warning: Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting, or G.I. bleeding occur.

Precautions: The dosage of ganglionic blocking agents, veratrum, or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Electrolyte disturbances are possible in cirrhotic or digitalized patients.

Side Effects: Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, and rashes may occur.

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to reduce excess fluid
or high blood pressure



"The Priceless Ingredient" of every product
is the honor and integrity of its maker



11:47 pm



11:53 pm



12:06 am

The meaningful pause. The energy it gives. The bright little lift. Coca-Cola with its never too sweet taste, refreshes best. Helps people meet the stress of the busy hours. This is why we say

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better
with
Coke
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An Institution for the diagnosis and treatment of Psychiatric and Neurological illnesses, rest, convalescence, drug and alcohol habituation.

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Wm. Ray Griffin Jr., M.D.
Robert A. Griffin, M.D.

Mark A. Griffin Sr., M.D.
Mark A. Griffin Jr., M.D.

Frankly, most antihyper-
tensives are pretty good if
you give an adequate dose.
I'm looking for one with a
simple regimen so that mix-
ups in doses and therefore
the chance of side effects
are minimized.



Regroton®

chlorthalidone 50 mg. reserpine 0.25 mg.

One tablet daily
brings pressure down

Advantage: Both components of Regroton
are long-acting.

Average dosage: One tablet daily with
breakfast.

Contraindications: History of mental
depression, hypersensitivity, and most
cases of severe renal or hepatic diseases.

Warning: Discontinue 2 weeks before
general anesthesia, 1 week before electro-
shock therapy, and if depression or
peptic ulcer occurs. With administration
of enteric-coated potassium supplements,
the possibility of small bowel lesions
should be kept in mind.

Precautions: Reduce dosage of con-
comitant antihypertensive agents by one-
half. Discontinue if the BUN rises or
renal dysfunction is aggravated. Electro-
lyte imbalance and potassium depletion
may occur; take particular care in
patients with cirrhosis or severe ischemic heart disease,
and in patients receiving corticosteroids,
diuretics, or digitalis. Salt restriction is not
recommended. Use with caution in
patients with ulcerative colitis, gall-
stones, or bronchial asthma.

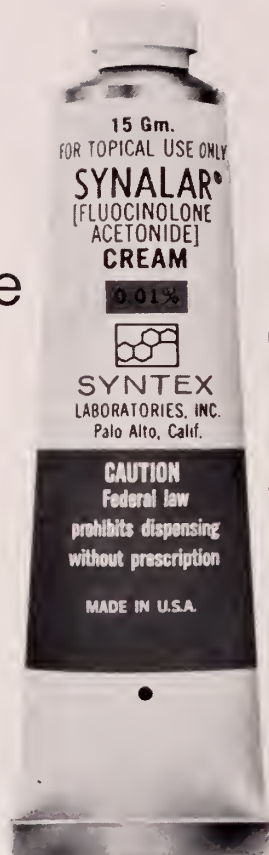
Side effects: Nausea, vomiting, diarrhea,
muscle cramps, headaches and dizziness.
Potential side effects include angina pecto-
ris, anxiety, depression, drowsiness,
hyperglycemia, hyperuricemia, lassitude,
leukopenia, nasal stuffiness, nightmare,
purpura, urticaria, and weakness.

For full details, see the complete prescrib-
ing information.

Availability: Bottles of 100 and 1000 tablets.

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new small size



Synalar® 0.01%
(fluocinolone acetonide) cream
15 Gm.

for even greater
economy in
office or hospital
practice

the superiority topical with the

Now you can prescribe as little or as much Synalar Cream 0.01% as is needed for a particular therapeutic problem in a size that permits the greatest economy for your patient. The new 15 Gm. tube, for example, is best suited for short-term therapy and for small sites. For more extensive body areas prescribe the 45 Gm. tube—a size that's also ideal for your treatment table. And the 120 Gm. jar is most economical for hospital use. Thus, with Synalar Cream 0.01%, you have the superiority of a modern topical corticosteroid shown to be more effective than 1% hydrocortisone¹⁻³ plus the economy that makes therapy practical for use in more dermatologic conditions, in long-term maintenance, with occlusive dressings in resistant cases, and in extensive area involvement.

Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of its components. **Precautions:** 1. *General*—Synalar Cream 0.01% is virtually nonsensitizing and nonirritating. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to

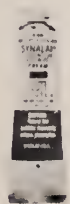
have an adverse effect on pregnancy, the safety of their use on females has not absolutely been established. Therefore, they should be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. 2. *Occlusive dressing method*—With occlusion of large areas, systemic absorption of the corticosteroid may occur, and precautions should be taken. Occasional patients may show sensitivity to a particular dressing material or adhesive. Miliaria, folliculitis, pyodermas have been seen infrequently with the use of this technique. Development of infection requires appropriate antibacterial therapy. Continuation of the occlusive dressing method. Local atrophy has been reported with protracted occlusive dressing therapy. When relapses can be expected to occur in many psoriatic patients, relapse may persist for several weeks to several months in favorable cases. A patient whose psoriasis is in an active stage, with recent appearance of lesions, may not be a good candidate and may show early relapse. Plastic films may be flammable, and due care should be exercised in use. Similarly, caution should be employed when such films are used near children to avoid the possibility of accidental suffocation. **Effects:** Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may respond favorably to Synalar under certain conditions. **References:** 1. Cahn, M. J., Levy, E. J. *J. New Drugs* 1:262 (Nov.-Dec.) 1961. 2. Meenan, F. C. *Med Ass* 52:75 (Mar.) 1963. 3. Robinson, H. M., Jr., Raskin, J., and W. J. R. *Southern Med J* 56:797 (Jul.) 1963.

of a modern corticosteroid economy of hydrocortisone

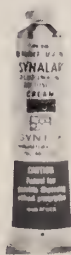
Now... a choice of 3
economical sizes



120 Gm. jar



15 Gm. tube



45 Gm. tube

fluocinolone acetonide — an original steroid from

SYNTEX 
LABORATORIES INC., PALO ALTO, CALIF.

at Merck Sharp & Dohme...



understanding... precedes development

The synthesis of cortisone was accomplished by Merck Sharp & Dohme in 1948—the famous “Compound E” used by Dr. Philip Hench in his historic experiment at the Mayo Clinic.

But proud as we are of our role in the development of cortisone and subsequent corticosteroids, we have continued to seek a greater understanding of arthritic disorders

and new drugs for their treatment.

One such drug—INDOCIN® (indomethacin), a nonsteroid, anti-inflammatory agent fundamentally different in structure and activity from other drugs in use—was recently made available for the treatment of arthritic conditions. It opens new possibilities for the long-term management of arthritis and inflammatory disease.



MERCK SHARP & DOHME

Division of Merck & Co., Inc., West Point, Pa.

where today's theory is tomorrow's therapy

INDOCIN[®]

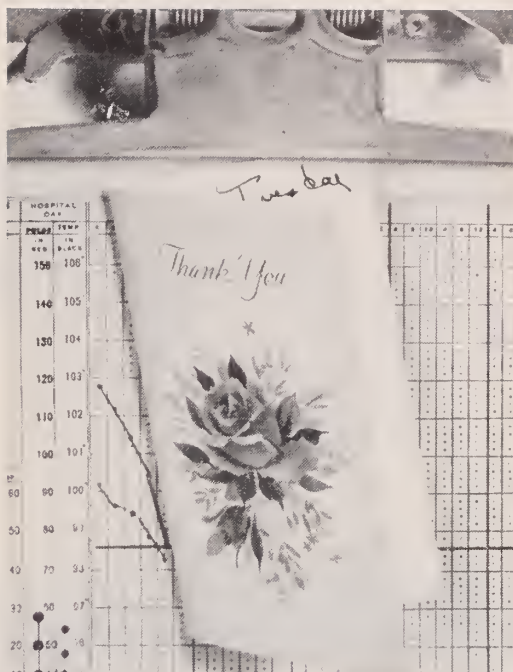
INDOMETHACIN

Indications: Chronic and acute rheumatoid arthritis, rheumatoid (ankylosing) spondylitis, degenerative joint disease (osteoarthritis) of the hip, and gout.

Contraindications: Active peptic ulcer, gastritis, regional enteritis, or ulcerative colitis. Safety in pregnancy has not been established. Not recommended for pediatric age groups.

Warning: Patients who experience dizziness, lightheadedness, or feelings of detachment on INDOCIN should be cautioned against operating motor vehicles, machinery, climbing ladders, etc. Use cautiously in patients with psychiatric disturbances, epilepsy, or parkinsonism.

Precautions and Adverse Reactions: Most commonly, headache, dizziness, lightheadedness, G.I. disturbances. The C.N.S. effects are often transient and frequently disappear with continued treatment or reduced dosage. The severity of these effects may occasionally require cessation of therapy. G.I. effects may be minimized by giving the drug with food or with antacids or immediately after meals. Ulceration of the stomach, duodenum, or small intestine has been reported and, in a few instances, severe bleeding with perforation and death. Gastrointestinal bleeding with no obvious ulcer formation has also been noted; INDOCIN should be discontinued if G.I. bleeding occurs. As a result of G.I. bleeding, some patients may manifest anemia, and for this reason periodic hemoglobin determinations are recommended. Rare reports of effects not definitely known to be attributable to INDOCIN include bleeding from the sigmoid colon (either from a diverticulum or without a known previous pathologic condition), perforation of preexisting sigmoid lesions (diverticulum, carcinoma), and hematuria. In other rare cases, a diagnosis of gastritis has been made while the drug was being given. One patient developed ulcerative colitis, and another, regional ileitis, while receiving INDOCIN; when the drug was given to patients with preexisting ulcerative colitis, there was an increase in abdominal pain. Infrequently observed side effects may include drowsiness, tinnitus, mental confusion, depression and other psychic disturbances, blurred vision, stomatitis, pruritus, edema, and hypersensitivity reactions. Slight BUN elevation, usually transient, has been seen in some patients, although the preponderance of evidence indicates that INDOCIN does not adversely affect renal function, even in patients with preexisting renal disease. Nevertheless, renal function should be checked periodically in patients on long-term therapy. Leukopenia has been seen in a few patients. Transient elevations in alkaline phosphatase, cephalin-cholesterol flocculation, and thymol turbidity tests have been observed in some patients and, rarely, elevations of SGOT values; the relationship of these changes to the drug, if any, has not been established. As with any new drug, patients should be followed carefully to detect unusual manifestations of drug sensitivity. Before prescribing or administering, read product circular with package or available on request.



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It can happen. Send for our free booklet and see the remarkable things that can be done with a diet that is built on Cream of RICE.

It's called "How To Make A Special Diet Taste Extra Special!" You'll find delicious recipes for bland, wheat-free, milk-free, egg-free and low-salt diets.

A recent research study compared the breakdown of Cream of RICE with oat, wheat, corn and barley cereals and concluded that Cream of RICE was easiest to digest.

Cream of RICE is fortified with Vitamin B₁, Riboflavin, Niacin and Iron. And it's low in residue and fat. The patient gets dietary protection, flavor satisfaction and good nutrition. And you may actually get a "Thank you."



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The AMA's first clinical convention in Las Vegas offers a top notch scientific postgraduate program.

Scientific sessions will be held on the following topics: Scintillation Scanning • Radiation and Cancer • Clinical Pulmonary Physiology • Gastroenterology • Futuristic Diagnostic and Therapeutic Tools • Neck Pain • Antibiotics • Urology • Aerospace Medicine • Unconsciousness • Dermatology • Juvenile Diabetes • Endocrine and Metabolic Diseases • Pediatrics • Surgery • Hematology • Psychiatry • Otolaryngology.

Three Postgraduate Courses will be presented: Obstetrics and Gynecology • Fluid and Electrolyte Balance • Cardiovascular Disease. Each Course will consist of three half-day sessions, and there will be a registration fee of \$10.00 for each course, payable with your advance registration.

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The complete scientific program, plus forms for advance registration and hotel accommodations, will be featured in JAMA October 24.

Meetings

October

20-22 "Industrial Medicine, The Doctors Role in Occupational Health," Mound Park Hotel Auditorium, St. Petersburg.

27-29 Neurology-Neurosurgery Seminar, University of Florida, Gainesville.

November

10-12 Pediatric Seminar, University of Florida, Gainesville.

17-18 Obstetrics and Gynecology Seminar, University of Florida, Gainesville.

17-19 "Pediatric Neurology," Florida Pediatric Society Fall Meeting, Beach Club Hotel, Ft. Lauderdale.

December

1- 3 "The Lower Extremity Amputee—Surgical and Prosthetic Management," University of Miami, Americana Hotel, Miami Beach.

1- 4 Fourth Annual Cardiology Seminar, Revere Heart Foundation, Tides Bath Club, St. Petersburg.

January

2- 6 Neuro-Ophthalmology Symposium, Bascom Palmer Eye Institute, Americana Hotel, Bal Harbour.

5- 7 Postgraduate Seminar in Surgery, University of Miami Department of Surgery and Miami Fontainebleau Hotel, Miami Beach.

15-20 "Acid Base Disorders in Internal Medicine, Surgery and Pediatrics," University of Miami School of Medicine, Fontainebleau Hotel, Miami Beach.

March

17 Psychiatry Seminar, University of Florida College of Medicine, Gainesville.

Doctor,

Here is the Abbott anorectic program designed to meet the individual needs of your overweight patients.



mood elevation

Abbo
Anorect
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DESOXYN® Gradumet® (methamphetamine hydrochloride)

Smooth appetite control plus mood elevation.

The obese patient on a diet often has to battle depression as well as overweight. Desoxyn Gradumet helps the dieter in both battles by elevating the mood while it curbs the appetite. Thanks to the Gradumet, medication is smoothly released all-day from a single oral dose.

If she can't take plain amphetamine put her on DESBUTAL® Gradumet

Calms anxieties; controls compulsive eating.

Desbutal Gradumet provides 2 drugs in 2 tablet sections, combined back to back to form a single tablet. One section contains Desoxyn to curb the appetite and lift the mood; the other contains Nembutal® (pentobarbital) to calm the patient and counteract any excessive stimulation.

Both drugs are released in an effective dosage ratio throughout the day.



controlled release

Abbott
Anorectic
Program

Not all long-release vehicles are the same. Here is why the Gradumet is different and what it means for your overweight patients.



The release action is purely physical and relies on only one factor common to every patient: gastrointestinal fluid. There is no dependence on enteric coatings, enzymes, motility, or an "ideal" ion concentration in the gastrointestinal tract.

Your patients get a measured amount of medication, moment by moment, throughout the day.

They are not subjected to ups and downs of drug release . . . or to erratic release from patient to patient . . . or to erratic release in the same patient from day to day.

That's why the Gradumet provides controlled-release as well as long release.



Perhaps you saw the Gradumet model demonstration which shows that the release is entirely physical. When fluid is added, the drug in the outer ends of the channels dissolves. As fluid penetrates deeper into the channels, there is a continuous release of medication. The rate of release is rigidly controlled by the size and number of channels.

choice of 5 strengths

Abbott
Anorectic
Program

DESOXYN Gradumet

Methamphetamine Hydrochloride in Long-Release Dose Form



5 mg.



10 mg.



15 mg.

DESBUTAL 10 Gradumet

10 mg. Methamphetamine Hydrochloride,
60 mg. Pentobarbital Sodium



Front



Side

DESBUTAL 15 Gradumet

15 mg. Methamphetamine Hydrochloride,
90 mg. Pentobarbital Sodium



Front



Side

samples available



Each sample contains 6 tablets and a filled Sucaryl® Sweetener dispenser. For a supply, write Abbott Laboratories or ask your Abbott man.

Desbutal 15 Gradumet

Product of choice for patients who overreact to plain amphetamine

As an anorectic in treatment of obesity also to counteract anxiety and mild depression.

Desbutal is contraindicated in patients taking a monoamine oxidase inhibitor. Nervousness or excessive sedation have occasionally been observed. Often these effects will disappear after a few days. Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism or who are sensitive to sympathomimetic drugs. Careful supervision is advisable with maladjusted individuals.

A single Gradumet tablet in the morning provides all-day appetite control.

Desbutal 10 contains 10 mg. of methamphetamine hydrochloride and 60 mg. of pentobarbital sodium. Desbutal 15 contains 15 mg. of methamphetamine hydrochloride and 90 mg. of pentobarbital sodium. In bottles of 100 and 500.



Sucaryl Sweeteners

A proven aid to weight control—

For use in beverages and foods—stable to heat

A constant reminder to your patient to "watch her calories"

A carefully balanced formula to prevent aftertaste

—in tablets and liquid—

Sucaryl—Abbott brand of low and non-caloric sweeteners

Press out tablets from this side

LOT NO. 784 1321



For:

Directions:

Or.



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economy

Patients, in many cases, save enough to get five weeks of medication for the price of four, compared to other leading long-release anorectics.

CONTRAINDICATION: Desoxyn and Desbutal are contraindicated in patients taking a monoamine oxidase inhibitor.

PRECAUTIONS: Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs or ephedrine and its derivatives. Careful supervision is advisable with maladjusted individuals.



Gradumet—long-release dose form, Abbott: U.S. Pat. No. 2,987,445
Sucaryl—Abbott brand of low and non-caloric sweeteners.

Soyalac SOLVES THE PROBLEM

...and BABY APPROVES!

Baby has a thing or two to say about a hypo-allergenic, milk-free diet!

Soyalac is the good-tasting, fibre-free formula that infants readily accept. The exclusive Soyalac process results in a consistency much like milk, with a light, creamy color — and nut-like flavor but without a trace of sediment.

Soyalac satisfies the infant. Strikingly similar to mother's milk, it provides protein of high biologic value and balanced nutrients. Clinical data furnish evidence of Soyalac's excellence in promoting normal growth and development.



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1966-67 Postgraduate Seminars

University of Florida College of Medicine

Date	Title	Location
October 27-29, 1966	Neurology-Neurosurgery Seminar	All Seminars will be held at the University of Florida, Gainesville
November 10-12, 1966	Pediatric Seminar	
November 17-18, 1966	Obstetrics & Gynecology Seminar	
March 17, 1967	Psychiatric Seminar	
April 13-14, 1967	Obstetrics & Gynecology Seminar	

University of Miami School of Medicine

Date	Title	Location
December 1-3, 1966	The Lower Extremity Amputee—Surgical and Prosthetic Management	Americana Hotel, Bal Harbour
January 2-6, 1967	Neuro-Ophthalmology Symposium	Americana Hotel, Bal Harbour
January 4-6, 1967	Gastro-Intestinal Surgery Seminar	Fontainebleau Hotel, Miami Beach
January 5-7, 1967	Anesthesiology—Metabolic and Endocrine Disorders Seminar	Eden Roc Hotel, Miami Beach
January 12-15, 1967	Central Nervous System Neoplasms—Diagnosis and Treatment	Eden Roc Hotel, Miami Beach
January 15-20, 1967	Acid Base Disorders in Internal Medicine, Surgery and Pediatrics	Fontainebleau Hotel, Miami Beach
February 12-19, 1967	Ophthalmology & Otolaryngology	Americana Hotel, Bal Harbour
February 9 to May 25, 1967	Psychiatry in Medical Practice—Basic Course	Jackson Memorial Hospital, Miami
February 9 to May 25, 1967	Psychiatry in Medical Practice—Advanced Course	Jackson Memorial Hospital, Miami
March 20-23, 1967	Genitourinary Roentgenology—Current Status	Fontainebleau Hotel, Miami Beach
June 5-7, 1967	Rehabilitation of Head and Neck Cancer Patients and Esophageal Speech Course	University of Miami School of Medicine

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"In 40 of 44 cases of irritable or spastic colon, Cantil [mepenzolate bromide] or Cantil with Phenobarbital reduced or abolished abdominal pain, diarrhea and distention and promoted restoration of normal bowel function . . . Cantil [mepenzolate bromide] proved to be singularly free of anticholinergic side-effects . . . Urinary retention, noted in two cases was eliminated in one by reducing dosage."

CANTIL[®]

(mepenzolate bromide)

helps restore normal motility and tone

IN BRIEF:

One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

Supplied: CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

1. Riese, J.A.: Amer. J. Gastroent., 28:541 (Nov.) 1957

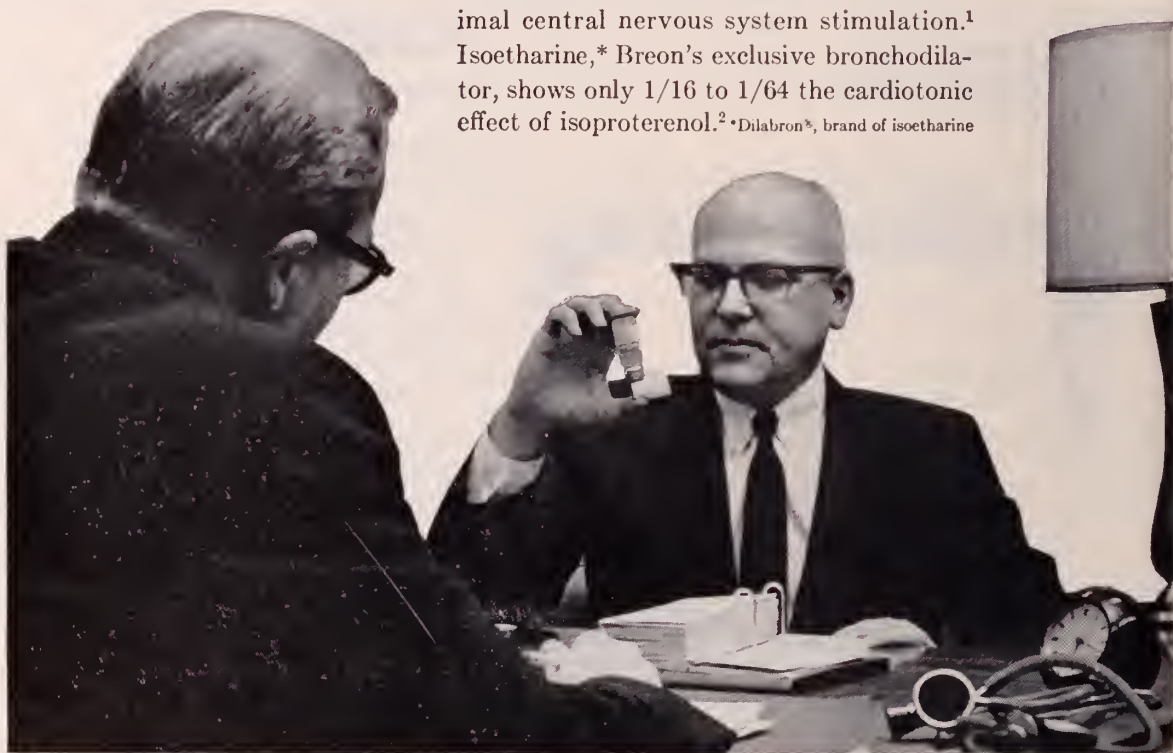
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Patients feel relaxed with Bronkometer. Its bronchodilator-decongestant action has minimal central nervous system stimulation.¹ Isoetharine,* Breon's exclusive bronchodilator, shows only 1/16 to 1/64 the cardiostimulant effect of isoproterenol.² *Dilabron®, brand of isoetharine



BRONKOMETER[®] ASTHMA, CHRONIC BRONCHITIS, EMPHYSEMA

isoetharine 0.6%; phenylephrine 0.125%; thenyldiamine 0.05%—Superior because it contains isoetharine

COMPOSITION: Bronkometer delivers at the mouthpiece 200 metered doses of: 350 mcg isoetharine methanesulfonate (0.6%); 70 mcg phenylephrine HCl (0.125%); and 30 mcg thenyldiamine HCl (0.05%) with saccharin, menthol and fluorochlorohydrocarbons as inert propellants. Preserved with ascorbic acid 0.1% and alcohol 30%.

RECOMMENDED DOSAGE: One or two inhalations with at least one minute between inhalations. Occasionally more may be required, however in most cases, inhalations need not be repeated more than every four hours. Dosage should be adjusted to the severity of the condition and to patient's response.

PRECAUTIONS: Bronkometer is unusually free from cardiovascular and other side effects, but the usual precautions associated with sympathomimetic amines should be observed. Bronkometer should not be administered simultaneously with epinephrine or similar compounds because of the possibility of tachycardia, although it may be alternated with these agents. Dosage must be carefully adjusted in patients with hyperthyroidism, hypertension, acute coronary disease, cardiac asthma, limited cardiac reserve and in individuals sensitive to sympathomimetic amines.

SUPPLIED: 10 ml pressurized aerosol vials complete with measured dose valve and oral nebulizer.

References: 1. Spielman, A. D.: *Curr. Therap. Res.* 3:235 (June) 1961. 2. Herschfus, J. A.; Bresnick, E.; Levinson, L.; and Segal, M. S.: *Ann. Allergy* 9:769 (Nov.-Dec.) 1951.

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DACTILASE®

Each tablet contains:

Dactil® (piperidolate hydrochloride), 50 mg.;
Standardized cellulolytic* enzyme, 2 mg.;
Standardized amylolytic enzyme, 15 mg.;
Standardized proteolytic enzyme, 10 mg.;
Pancreatin 3X** (source of lipolytic activity),
100 mg.; Taurocholic acid, 15 mg.

*Need in human nutrition not established.

**As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.

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ARE ALL
BUTTERFLIES

AND
GAS



In chronic or acute indigestion, fluttery, gassy stomachs obtain prompt, gratifying relief through the antispasmodic, surface anesthetic and enzymatic activity of Dactilase. Dactilase decreases hypermotility and pain and reduces the production of gas. Dactilase does not induce stasis, but helps restore normal tone. It has little or no effect on enzyme secretions, but *adds* enzymes, thus contributing to the digestive efficiency of the patient.

Side Effects and Contraindications:

Dactilase is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

Administration and Dosage: One tablet with, or immediately following, each meal. Tablets should be swallowed whole.

Supplied: Bottles of 60 and 250.

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following infection

B and C vitamins are therapy: STRESSCAPS B and C vitamins in the peutic amounts...help the body mobilize defenses during convalescence... response to primary therapy. The patient with a severe infection, and many others undergoing physiologic stress, may benefit from STRESSCAPS capsules.



Stresscaps[®]

Stress Formula Vitamins Lederle



Each capsule contains:
 Vitamin B₁ (as Thiamine Mononitrate) 10 mg
 Vitamin B₂ (Riboflavin) 10 mg
 Vitamin B₆ (Pyridoxine HCl) 2 mg
 Vitamin B₁₂ Crystalline 4 mcgm
 Vitamin C (Ascorbic Acid) 300 mg
 Niacinamide 100 mg
 Calcium Pantothenate 20 mg
 Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

**WARMTH
FOR COLD
HANDS AND FEET**



For cold hands and feet, nothing beats hot stoves—but they *are* awkward to carry around. Now Gerilid, in good-tasting take-along chewable tablets can provide rapid vasodilation of peripheral circulation, bringing real warmth to the extremities and decreasing sensitivity to sudden temperature change. Patients *like* Gerilid and *know* they are getting relief.

GERILID™

Each chewable tablet contains:
nicotinic acid (niacin) 75 mg. and
aminoacetic acid (glycine) 750 mg.

Administration and Dosage: One or two chewable tablets 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation. The recommended dosage should not be exceeded.

Side effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is a concomitant administration of a coronary vasodilator.

Supplied: Packages of 50 chewable tablets.

Also available in liquid form as Geriliquid®, in bottles of 8 and 16 ounces.

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Winthrop announces new

WinGel®

ANTACID
TABLETS
AND LIQUID

**For peptic ulcer,
gastric hyperacidity,
gastritis**

Each WinGel tablet or teaspoon (5 ml.) contains 410 mg. of combined, highly reactive, short polymer, aluminum and magnesium hydroxides stabilized with hexitol.

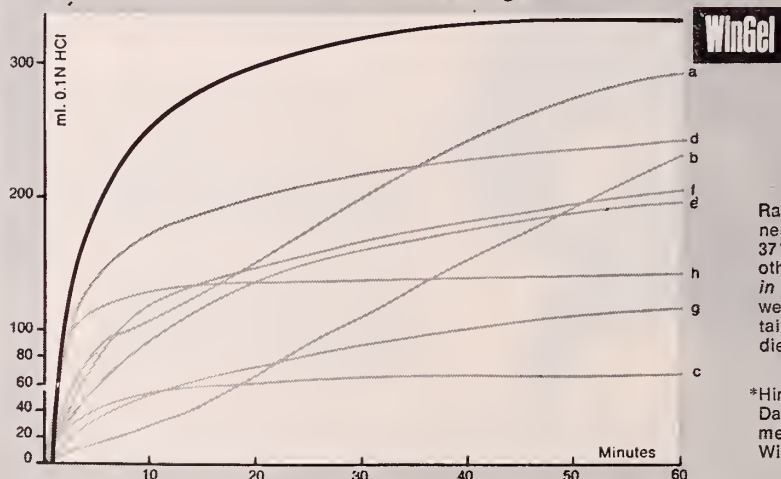
Neutralizes 300 times its active-ingredient weight in gastric acid for fast, long-lasting relief

Gastric or duodenal ulcer, acute or chronic gastritis, gastric hyperacidity...wherever there is "acid overflow" new WinGel can provide faster, longer, more complete neutralization.

In recent laboratory comparisons* with eight other leading antacids, new WinGel tablets not only neutralized more hydrochloric acid per active-ingredient weight, but neutralized it faster and longer than all other antacids tested.

Pleasant pink in color, WinGel is delicately mint flavored with a smooth-as-cream texture—qualities sure to please the patient on long-term therapy. New WinGel is also specially formulated to avoid constipation or diarrhea.

New WinGel neutralizes 300 times its active-ingredient weight in 0.1N hydrochloric acid—neutralizes more acid faster than other leading antacids




Rate of 0.1N hydrochloric acid neutralization at pH 3.5 and 37° with WinGel and eight other leading antacid tablets—in vitro. Samples equaled the weight of tablet material containing 1.0 Gm. active ingredients.*

*Hinkel, E. T., Jr. (New York): Data in the files of the Department of Medical Research, Winthrop Laboratories.

Dosage: Peptic ulcer or gastritis—from 2 to 4 teaspoons of WinGel liquid or 2 to 4 tablets chewed or allowed to dissolve in the mouth every two to four hours. Gastric hyperacidity—2 tablets or teaspoons about ½ to one hour after meals as needed; children from 7 to 14 years of age, 1 or 2 tablets or 1 or 2 teaspoons of liquid as needed.

How Supplied: Liquid in bottles of 8 fl. oz. and 1 pint. Tablets in cellophane strips, boxes of 50 and 100. (One teaspoon of WinGel liquid is equivalent to one WinGel tablet in acid-combining capacity.) WinGel, trademark reg. U.S. Pat. Off.

Winthrop Laboratories, New York, N.Y. 10016 

Finally — a taste your patients will truly like

(10584)

WHAT'S THE
COMMON
DENOMINATOR? ... IRON



In fact, there's as much iron...250 mg.
...in a 5 cc. ampul of Imferon (iron dextran
injection) as in a pint of whole blood.
When iron deficient patients are intolerant
of oral iron...or orally administered iron
proves ineffective or impractical...or if
the patient cannot be relied upon to take oral
iron as prescribed, Imferon (iron dextran
injection) dependably increases hemoglobin
and rapidly replenishes iron reserves.

IMFERON® (iron dextran injection)

IN BRIEF: ACTION AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion as a source of iron; infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb/100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. Initial test doses are advisable. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylatoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201



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FOR A CLEAN START IN VAGINITIS THERAPY

superior cleansing action ■ STOMASEPTINE's oxidizing and mucolytic properties promote thorough cleansing of the vaginal vault. Dissolves and removes irritating secretions more effectively than vinegar which tends to coagulate glycoproteins. Low surface tension and release of nascent oxygen contribute to deep penetration and cleansing of rugae.

enhances specific therapy ■ Removal of vaginal debris with STOMASEPTINE enhances the effectiveness of specific therapy...ensures maximum contact of topical medication with vaginal mucosa.

excellent patient acceptance ■ Anti-pruritic and deodorizing...pleasantly scented...patients feel "fresh and clean."

Contains: sodium perborate, sodium bicarbonate, sodium chloride, sodium borate, menthol, thymol, eucalyptol, methyl salicylate and aromatics—6 oz. and 15 oz. jars; cartons of 12 10-gm. packets

Literature and professional supply on request.

HARCLIFFE LABORATORIES, INC. BROOKLYN, New York 11217

STOMASEPTINE®
DOUCHE POWDER

**SAVES
LIVES
SAVES
MONEY
WASTES
WATER**



METAHYDRIN (trichlormethiazide) is prescribed by physicians because it not only approximates the diuretic efficacy of parenteral meralluride injection . . . but, *it is the least expensive of all "brand-name" thiazides.* Therefore, when you prescribe METAHYDRIN (trichlormethiazide) your patients receive the thiazide diuretic that removes a little more salt and water than earlier thiazides, with relatively less loss of potassium . . . and, it's therapy they can more easily afford . . . *only pennies a day.*

METAHYDRIN® (trichlormethiazide) oral diuretic

Dosage: One 2 or 4 mg. tablet once or twice daily.

Precautions: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

Side Effects: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have occasionally been noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by the administration of thiazides.

Contraindications: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

How Supplied: Bottles of 100 and 1000 tablets.

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Contact: Medical Director, Highland Hospital, Asheville,
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A non-profit, psychiatric institution, offering therapeutic milieu, group and individual psychotherapy, and standard somatic treatments. Limited day-patient and out-patient services. The hospital is located in a 75-acre park amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and emotional rehabilitation.

**BRING IT DOWN
AND
KEEP IT DOWN**

190
102

Metatensin lowers blood pressure and keeps it low—effectively and economically. It combines reserpine with trichlormethiazide which affords more potent saluresis with less loss of potassium than from earlier thiazides. Reserpine contributes antihypertensive effect by relieving anxiety and tension. Metatensin is well-tolerated over long periods; with its effectiveness and economy it assures antihypertensive therapy you and your patients can stay with.

METATENSIN®

Each scored tablet contains:
METAHYDRIN® (trichlormethiazide)
2 mg. or 4 mg. and
Reserpine 0.1 mg.

Usual adult dose: One tablet twice daily. **Precautions and side effects:** Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery.

Contraindications: Complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.

Supplied: Metatensin tablets, 2 mg., 4 mg.—bottles of 100 and 1000.

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WHEN
THE BACTERIAL U.R.I.
SETTLES
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ACHROCIDIN®

Tetracycline HCl-Antihistamine-Analgesic Compound

Each tablet contains:

ACHROMYCIN® Tetracycline HCl 125 mg
Phenacetin 120 mg

Caffeine 30 mg
Salicylamide 150 mg
Chlorothen Citrate 25 mg

The patient can feel better while getting better. ACHROCIDIN brings the treatment together in a single prescription—prompt symptomatic relief together with early, potent control of the tetracycline-sensitive organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

Effective in controlling complicating tetracycline-sensitive bacterial infection and providing symptomatic relief in allergic diseases of the upper respiratory tract.

Contraindication—History of hypersensitivity to tetracycline.

Warning—If renal impairment exists, even usual doses may lead to liver toxicity. Under such conditions, lower than usual doses are indicated and if therapy is prolonged, tetracycline serum level determination may be advisable. Hypersensitive individuals may develop a photodynamic reaction to natural or artificial sunlight during use. Individuals with a history of photosensitivity reactions should avoid direct exposure while under treatment and treatment should be discontinued at first evidence of skin discomfort.

Precautions—Some individuals may experience drowsiness, ano-

rexia, and slight gastric distress. If excessive drowsiness occurs, it may be necessary to increase the interval between doses. Persons on full dosage should not operate any vehicle. Use may result in overgrowth of nonsusceptible organisms. If infections appear during therapy, appropriate measures should be taken. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Infections caused by beta-hemolytic streptococci should be treated for at least 10 full days to help prevent rheumatic fever or acute glomerulonephritis. Use of tetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect has been observed in usual short treatment courses.

Average adult dosage: 2 tablets four times daily, given at least one hour before, or two hours after meals.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

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When depressed patients say:



"I can't sleep at night"



"I'm tired all day long"

NORPRAMIN[®] (desipramine hydrochloride) non-sedating • rapid-acting ANTIDEPRESSANT

helps restore normal patterns of sleep and activity

Norpramin (desipramine hydrochloride) often reverses the signs and symptoms of depression including sleep disturbances, feeling of sadness, guilt, anxiety, worthlessness and bodily complaints without physical basis. In 2-5 days most patients become more hopeful, active and less weighed down by their problems.

Norpramin (desipramine hydrochloride) has only slight sedative qualities, nevertheless sleep disturbances and restlessness are relieved as depression is lifted. If anxiety or tension develop or persist a tranquilizer may be added or dosage reduced. Side effects are usually mild, occurring in about 1 of 4 patients.

Indications: In moderate to severe depression—neurotic or psychotic. **Dosage:** Optimal results are obtained at a dosage of two 25 mg. tablets t.i.d. (150 mg./day). **Contraindications and Precautions:** Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease and epilepsy. Should not be given within two weeks of an MAO inhibitor. Safety in human pregnancy has not been established. **Adverse Effects:** Usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste", sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs. **Supplied:** Norpramin (desipramine hydrochloride) tablets of 25 mg., in bottles of 50, 500 and 1000.

PRODUCTS FOR PATIENTS YOU SEE EVERY DAY



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Behind continued high blood pressure readings lies the possibility of organic damage¹⁻¹³

MANY OF THE aspects of essential hypertension are unpredictable—either because there are a number of mechanisms involved or because individuals differ in their responses to these mechanisms.¹

There is one aspect of hypertension, however, that seems, in many cases, predictable. "... when the blood pressure is elevated to a marked degree for an adequate period of time, this in itself leads to perpetuation of the syndrome with resulting vascular damage throughout the body."¹⁴ All too often the disease progresses until there is damage to one of three vital organs: the heart, the kidney, the brain.



"Hypertension is certainly a major factor in the genesis of coronary heart disease, and it is even more important when compounded with obesity."⁴

"[Vascular deterioration] can be clearly seen in the kidney with a degree of damage that can be measured by renal function studies."¹⁰

"... most evidence suggests that reduction of blood pressure, when it is too high, not only relieves the heart of excess work but reduces vascular damage."¹

"In short, treatment is indicated."¹

Antihypertensive therapy will not restore the blood vessels to normal. Yet many of the vascular changes and symptoms caused by increased blood pressure may be arrested or alleviated when the blood pressure is reduced to normotensive levels.⁷

Reducing the blood pressure helps curtail further vascular damage and improves the prognosis — when damage is not too far advanced before therapy is started.¹⁴ Essential hypertension is an indication not only for treatment, but for early and adequate treatment of the patient in question.

Reduce the blood pressure with Rautrax-N

Rautrax-N combines the antihypertensive-tranquilizing action of whole root rauwolfia with the antihypertensive-diuretic action of bendroflumethiazide in one convenient medication. The two drugs complement each other

so that smaller doses of both are possible.

Rauwolfia combined with bendroflumethiazide is particularly effective in long-term therapy,¹⁵⁻¹⁷ since beneficial effects do not diminish with continuous daily administration.

For most patients 1 or 2 Rautrax-N tablets daily are sufficient for maintenance therapy. The simplicity, convenience and economy of such a dosage schedule are of particular benefit to older patients.

References: 1. Page, I. H., and Dustan, H. P.: The Usefulness of Drugs in the Treatment of Hypertension, in Ingelfinger, F. J.; Relman, A. S., and Finland, M.: *Controversy in Internal Medicine*, Philadelphia, W. B. Saunders Co., 1966, p. 95. 2. Hollander, W.: The Evaluation of Antihypertensive Therapy of Essential Hypertension in Ingelfinger, F. J.; Relman, A. S., and Finland, M.: *Controversy in Internal Medicine*, Philadelphia, W. B. Saunders Co., 1966, p. 97. 3. Nickerson, M.: Antihypertensive Agents and the Drug Therapy of Hypertension, in Goodman, L. S., and Gilman, A.: *The Pharmacological Basis of Therapeutics*, ed. 3, New York, The Macmillan Co., 1965, p. 727. 4. Berkson, D. M.: *Indust. Med. & Surg.* 32:371, 1963. 5. Cohen, B. M.: *M. Times* 91:645, 1963. 6. Lee, R. E., et al.: *Am. J. Cardiol.* 11:738, 1963. 7. Moyer, J. H.: *Am. J. Cardiol.* 9:821, 1962. 8. Moser, M.: *New York J. Med.* 62:1177, 1962. 9. Wood, J. E., and Battey, L. L.: *Am. J. Cardiol.* 9:675, 1962. 10. Moyer, J. H., and Heider, C.: *Am. J. Cardiol.* 9:920, 1962. 11. Moser, M., and Macaulay, A. I.: *New York State J. Med.* 60:2679, 1960. 12. Judson, W. E.: *Nebraska M. J.* 44:305, 1959. 13. Hodge, J. V.; McQueen, E. G., and Smirk, H.: *Brit. M. J.* 1:5218, 1961. 14. Moyer, J. H., and Brest, A. N.: *Hypertension Recent Advances*, Philadelphia, Lea & Febiger, 1961, p. 633. 15. Berry, R. L., and Bray, H. P.: *J. Am. Geriatrics Soc.* 10:516, 1962. 16. Reid, W. J. J.: *Am. Geriatrics Soc.* 13:365, 1965. 17. Feldman, L. H.: *North Carolina M. J.* 23:248, 1962.

Contraindications: Severe renal impairment or previous hypersensitivity. **Warning:** Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting or G.I. bleeding occur.

Precautions and Side Effects: The dose of ganglionic blocking agents, veratrum or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Caution is indicated in patients with depression, suicidal tendencies, peptic ulcer; electrolyte disturbances are possible in cirrhotic or digitalized patients. Marked hypotension during surgery is possible; consider discontinuing two weeks prior to elective surgery and observe patients closely during emergency surgery. Rauwolfia preparations may cause reversible extrapyramidal symptoms and emotional depression, diarrhea, weight gain, edema, drowsiness may occur. Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycosuria and glycosuria in diabetic patients, and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, rashes may occur.

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Deaths

Bencker, Frederick William, Lake Worth; born in Germany, Oct. 10, 1899; Temple University School of Medicine, Philadelphia, 1925; interned at Chester County Hospital, Westchester, Pa., and served residencies at St. Francis Hospital and Municipal Hospital, Philadelphia; entered military service in 1942 and served as a captain in the U. S. Army Medical Corps during World War II, retiring in 1945 with the rank of lieutenant colonel after extensive service in the European Theater as a member of one of the first medical units to be stationed overseas; engaged in the general practice of medicine in Havertown, Pa., for 16 years before locating in Lake Worth in 1946; held membership in the American Medical Association; died July 21 at his summer home in West Hyannisport, Mass., aged 66.

Falkiewicz, Rafal Antoni, Clearwater; born in Lwow, Poland, Oct. 14, 1931; Royal College of Surgeons, Dublin, Ireland, 1956; served an internship at Mt. St. Mary's Hospital, Niagara Falls, N.Y., 1956-1957, and residencies at Georgetown University Hospital and Sibley Memorial Hospital, Washington, D. C., 1957-1962; was instructor in anatomy at Georgetown University, 1959-1962; was a flight surgeon in the United States Air Force, 1962-1965; came to Clearwater in 1965 from Homestead Air Force Base, where he served as chief of surgery at the Air Force Base Hospital; held membership in the American Medical Association and the American Society of Abdominal Surgeons; died in a plane crash on May 5, aged 34.

Gaetano, Peter, Miami; born in New York City, 1891; Eclectic Medical College, Cincinnati, Ohio, 1927; interned in St. Barnabas Hospital, Newark, N. J.; engaged in the general practice of medicine in New York City from 1927 to 1950 and thereafter in Miami; had been a member of the Florida Medical Association since 1961; died March 13, aged 75.

Hazen, Olen B., Gainesville; born in 1893; Emory University School of Medicine, 1927; engaged in the general practice of medicine for 35 years in Gainesville, West Palm Beach and Nashville, Tenn.; also a lawyer, was admitted to The Florida Bar in 1941; represented Palm Beach County in the state legislature in 1931; held membership in the American Medical Association; died June 12, aged 73.

Heath, Henry Oliver, Pensacola; born in Butler County, Alabama, Aug. 11, 1874; University of Tennessee College of Medicine, Nashville, 1906; completed an internship and residency at Charity Hospital of New Orleans in 1910; engaged in the general practice of medicine for seven years in McLind, 17 years in Milton and more than a quarter of a century in Pensacola; was a member of the American Medical Association, and was a member of the Florida Medical Association for 50 years; died March 22, aged 91.

Hicks, Isham Kimbell, Melbourne; born in Jackson, Ala., Feb. 2, 1881; University of the South Medical Department, Sewanee, 1907; entered general practice with his father, Dr. L. O. Hicks, in Jackson; in 1915, moved to Jacksonville where he interned at St. Luke's Hospital and practiced during the war years; in 1922, located in Melbourne and continued in practice there for 44 years; served two terms as mayor of the city and was active in community affairs; was a member of the American Medical Association and for 20 years secretary of the Brevard County Medical Society; died June 6, aged 85.

Howe, Raymond, Daytona Beach; born in Burr Oak, Mich., June 3, 1880; University of Michigan Medical School, Ann Arbor, 1912; was a veteran of the Cuban War, serving as a private in the Thirty-Third Michigan Volunteer Infantry; taught briefly at his alma mater; engaged in the general

practice of medicine for more than half a century in Daytona Beach, where he was city physician for nine years and a former chief of staff of Halifax District Hospital; was a life member of the Volusia County Medical Society, Florida Medical Association and American Medical Association; died March 16, aged 85.

Leavitt, Herbert Audron, Fremont, Calif.; born in Kansas, Oct. 29, 1889; Hering Medical College, Chicago, 1913; interned at St. Francis Hospital, Evanston, Ill., 1913-1914; engaged in the general practice of medicine in Pompano, 1915-1920, and in Miami, 1920-1957; had been a member of the Florida Medical Association since 1925; was a member of the American Medical Association and the Florida Railway Surgeons; died April 3, aged 77.

Mathers, John Frederick, Orlando; born in Prosper, Texas, 1908; University of Texas Medical School, 1932; entered the practice of internal medicine in Orlando in 1937 after serving three years as resident physician at the University of Florida Infirmary, Gainesville; had a key role in the development of Orange Memorial Hospital, Orlando; was a founder and first president of the Florida Diabetic Association and was a longtime member of the Florida Crippled Children's Commission; held membership in the American Society of Internal Medicine, American Medical Association, Southern Medical Association, American College of Physicians, American Heart Association and American Geriatrics Association; was a diplomate of the American Board of Internal Medicine; during World War II, served four and a half years in the U. S. Army Medical Corps; died July 27, aged 58.

Ramel, William Joseph, Hollywood; born in Merchantville, N. J., Aug. 29, 1918; Jefferson Medical College of Philadelphia, 1945; interned at the U. S. Naval Hospital, Jacksonville, 1946 and completed his postgraduate studies at the Graduate School of Medicine of the University of Pennsylvania in 1951; served in the medical corps of the United States Navy, 1945-1948; engaged in the general practice of medicine in New Jersey for two years prior to locating in Hollywood in 1952; held membership in the American Medical Association; died May 24, aged 47.

Shirer, Ralph Francis Jr., St. Petersburg; born in New Orleans, La., Aug. 19, 1923; Tulane University School of Medicine, New Orleans, 1946; was an intern at Charity Hospital of New Orleans, 1946-1947, and a resident at New York Eye and Ear Infirmary, New York City, 1951-1954, served in the United States Air Force Medical Corps, 1942-1965, retiring from military service with the rank of lieutenant colonel; had engaged in the practice of otolaryngology in St. Petersburg since April 1965; held membership in the American Medical Association and Aerospace Medicine Association; died January 26, aged 42.

Sistrunk, James Franklin, Fort Lauderdale; born in Midway, Dec. 25, 1890; Meharry Medical College, Nashville, Tenn., 1919; was licensed to practice in Tennessee in 1919 and in Florida in 1920; practiced general medicine in Dunnellon for two years before locating in Fort Lauderdale in 1922; was an active member of the staff at Provident Hospital until it was closed and then became a member of the Broward General Hospital staff; from 1942 to 1944 operated a small hospital for county patients; was honored by the Broward County Commission in a recent resolution naming the new Northwest Sixth Street Bridge in Fort Lauderdale for him; held membership in the National Medical Association, Florida Medical, Dental and Pharmaceutical Association of which he was a former secretary, Broward County Medical Association, Florida Medical Association and American Medical Association; died March 20 after a long illness, aged 75.

Solomon, Henry Doyle Jr., St. Petersburg; born in Macon, Ga., 1925; Emory University School of Medicine, Atlanta, Ga., 1953; served an internship at the Johns Hopkins Hospital, Baltimore; then engaged in the general practice of medicine in St. Petersburg, his boyhood home; held membership in the American Medical Association; died suddenly on August 2, aged 41.

Spicola, Louis Angel, Tampa; born in Tampa, Oct. 13, 1908; New York Medical School and Flower Hospital, New York City, 1935; interned at Flower Hospital, and Christ Hospital, Jersey City, N. J., and served residencies at Christ Hospital, and New York Polyclinic Hospital, New York; a veteran of World War II, served in the

U. S. Army Medical Corps in Germany, 1942-1946; practiced in Lodi, N. J., 1938-1942, and since 1942 had engaged in the practice of urology in Tampa; held membership in the American Medical Association and American Urological Association and was a fellow of the American College of Surgeons; died suddenly after a heart attack on June 29, aged 57.

Tainter, Rolfe, Winter Park; born in Felton, Minn., Aug. 24, 1892; Northwestern University Medical School, Chicago, 1917; interned at the

U. S. Naval Hospital, Great Lakes, Ill.; after discharge from the medical corps of the U. S. Navy in 1919, engaged in postgraduate study at Northwestern University, 1919-1921; practiced ophthalmology in Fargo, N. D., 1921-1950 and in Orlando and the Southern Medical Association; died June forced his retirement; was a past president of the Cass County Medical Society, Fargo, and of the North Dakota Academy of Ophthalmology; was a member of the American Medical Association and the Southern Medical Association; died June 9, aged 73.

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NOVEMBER, 1966

Volume 53

Number 11

The **JOURNAL**
of the Florida Medical Association

In This Issue

Experience with Phenformin

Yarmouth Castle Disaster

Varicose Vein Surgery

Nephrotic Syndrome

Ulcerative Colitis

Uterine Cytology

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References: (1) Based on 23 clinical papers, 1512 cases. Bibliography on request. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: Antimicrobial Agents and Chemotherapy — 1964, Ann Arbor, American Society for Microbiology, 1965, p. 722.

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The JOURNAL

of the Florida Medical Association

Volume 53, Number 11, November 1966

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*A Key Site of Action of the
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"The main function of the
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the blood pressure...."¹

The veratrum component of
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through a generalized vaso-
dilation and fall in heart rate."²



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References: 1. Editorial: *JAMA* 191:592 (Feb. 15) 1965. 2. Meilman, E., in Moyer, J.H.: *Hypertension*, Philadelphia, W.B. Saunders Company, 1959, p. 395.

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Side Effects: *Hydroflumethiazide:* Purpura plus or minus thrombocytopenia, hyperuricemia, leukopenia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)

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Use with caution in lower than usual doses in cases with renal impairment to avoid accumulation of tetracycline and possible liver toxicity. If therapy is prolonged under such circumstances, tetracycline serum levels may be advisable. In long term therapy or with intensive treatment or in known or suspected renal dysfunction, periodic laboratory evaluation of the hematopoietic, renal and hepatic systems should be done. Formation of an apparently harmless calcium complex with tetracycline in any bone forming tissue may occur. Use of tetracycline during tooth development (3rd trimester of pregnancy, infancy and early childhood) may cause discoloration of the teeth. Reversible increased intracranial pressure due to an unknown mechanism has been observed occasionally in infants receiving tetracycline. Glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and definite allergic reactions occur rarely. Severe anaphylactoid reactions have been reported as due to triacytyleandomycin. Photosensitivity and photoallergic reactions (due to the tetracycline) occur rarely. Medication should be discontinued when evidence of significant adverse side effects or reaction is present. Patients should be carefully observed for evidence of overgrowth of nonsusceptible organisms including fungi, which occurs occasionally, and which indicates this drug should be discontinued and appropriate therapy instituted. Steps should be taken to avoid masking syphilis when treating gonorrhea.



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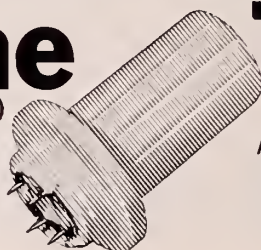
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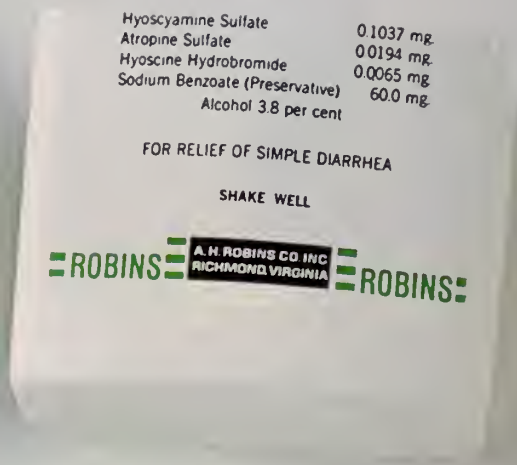
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References: 1. Kramer, P., and Ingelfinger, F.J.: Med. Clin. N. Amer., 32:1227, 1948. 2. Hock, C.W.: Clin. Med., 8:1932, 1961. 3. Winfield, I.W.: Am. J. Gastro-ent., 37:438, 1959.

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vignettes of angina pectoris —
no. 1 in a series:

angina and the surgeon

John Hunter —
British surgeon (1728-1793)

angina of anger

"My life is in the hands of any rascal who chooses to annoy and tease me."¹ So said the great British surgeon and anatomist, John Hunter, realizing that he could not control the anger which precipitated frequent and severe attacks of angina pectoris. According to Mettler: "His statement was no exaggeration. On October 16, 1793, he attended a meeting of the St. George's hospital staff, and, while defending the interests of several students, he was contradicted and thoroughly antagonized. The pains of angina commenced, he started toward another room, gained it, and fell dying into the arms of a physician."²

Why Edward Jenner withheld his paper on angina In 1777, at an earlier stage of the condition, Hunter's angina alarmed a favorite pupil, Edward Jenner, who wrote to Dr. Heberden that he feared his teacher was "affected with symptoms of the Angina Pectoris."³ So concerned was Jenner about his former teacher's emotion-related condition that he deliberately cancelled publication of a paper on angina pectoris, fearing that

Hunter would read it, and have "his fears excited by its truly formidable nature."⁴

Severity of angina described Hunter's brother-in-law, Dr. Everard Home, who witnessed his death and performed an autopsy, gave this account of the later stages of the condition:

"... the pain became excruciating at the apex of the heart; the throat was so sore as not to allow of an attempt to swallow anything and the left arm could not bear to be touched...."

"The affections above described were, in the beginning, readily brought on by exercise... but at last seized him when lying in bed, and in his sleep..."⁵



18th century ancestor of the modern coronary candidate. Surgeon, anatomist, pathologist, physiologist, geologist, and teacher, Hunter had a passion for research which led him to disregard his practice, his health and even his

When the Irish giant O'Brien learned that Hunter desired his lion for a museum, he willed his body be sunk at sea in a coffin. But Hunter was not to be denied. According to Major, he described the watchers and finally secured the body at a cost of 500 pounds although he had to borrow money to pay the men."³ In 1867, he experimentally inoculated himself with gonorrhea and, like his, treated himself with mercury for three years, and was eventually cured.⁵ Hunter had doubts of inadequacy about his education and speaking ability, but this did not prevent him from hard driving and abrupt treatment of his colleagues. His competitiveness with his physician older brother was also well known, and resulted in complete estrangement between the two men.^{2,3} Today, the personality traits seen in John Hunter are recognized to be important predisposing factors in the development of coronary artery disease—manifested as angina pectoris. According to Friedman and Rosenman in a group of men whose behavior was characterized by intense emotion and competitive drive, the rate rather than average incidence of angina pectoris was among those normal conditions noted.

References: 1. Paget, S., cited by Mettler, *A History of Medicine*, Philadelphia, Lippincott Company, 1947, p. 85. 2. Mettler, C. A.: *Op. cit.*, pp. 84-85. 3. Major, R. H.: *A History of Medicine*, Springfield, Ill., Charles C Thomas, 1954, pp. 601-607. 4. Baron, J., cited by Major, R. H.: *Op. cit.*, p. 607. 5. Major, R.: *Classic Descriptions of Disease*, ed. 3, Springfield, Ill., Charles C Thomas, 1955, p. 16. 6. Friedman, M., and Rosenman, R.: *J.A.M.A.* 169:1286, 1959.

in the modern
management of
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Sustained Action
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Each double-layer, biconvex, dark green/light green tablet of Peritrate SA Sustained Action contains:
pentaerythritol tetranitrate 80 mg.
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Peritrate (pentaerythritol tetranitrate) is a nitric acid ester of a tetrahydric alcohol (pentaerythritol).

Actions: The exact cause of angina pectoris (that is, the pain associated with coronary artery disease) remains obscure, despite the numerous and often conflicting hypotheses concerning its pathophysiology. Therapy at the present time, therefore, remains essentially empiric. Customarily, clinical improvement has been measured by: reduction in (1) number, intensity and duration of angina pectoris attacks and (2) necessity for glyceryl trinitrate intake for prevention or relief of anginal attacks.

Peritrate SA Sustained Action (pentaerythritol tetranitrate) 80 mg. has been reported in clinical usage to reduce in number and severity the incidence of angina pectoris attacks, with concomitant reduction in glyceryl trinitrate intake.

In the evaluation of Peritrate (pentaerythritol tetranitrate) and Peritrate SA Sustained Action (pentaerythritol tetranitrate) 80 mg. in angina pectoris, clinical improvement has been customarily measured subjectively by reduction in number and severity of attacks and necessity for glyceryl trinitrate intake for prevention or abortion of anginal attacks. Individual patterns of angina pectoris differ widely as does the symptomatic response to anti-anginal agents such as pentaerythritol tetranitrate. The published literature contains both favorable and unfavorable clinical reports. In conjunction with total management of the patient with angina pectoris, Peritrate (pentaerythritol tetranitrate) and Peritrate SA Sustained Action (pentaerythritol tetranitrate) 80 mg. have been accepted as safe for prolonged administration and widely regarded as useful.

Animal pharmacology: In a series of carefully designed studies in pigs, Peritrate (pentaerythritol tetranitrate) was administered for 48 hours before an artificially induced occlusion of a major artery and for seven days thereafter. The pigs were sacrificed at various intervals for periods up to six weeks. The result showed a significantly larger number of survivors in the drug-treated group. Damage to myocardial tissue in the drug-treated survivors was less extensive than in the untreated group. Pigs rather than dogs were used because their coronary artery distribution more closely resembles that of human beings. Studies in dogs subject to oligemic shock through progressive bleeding have demonstrated that Peritrate (pentaerythritol tetranitrate) is vasoactive at the post-arteriolar level, producing increased blood flow and better tissue perfusion. These animal experiments cannot be translated to human behavior.

Indications: Peritrate SA Sustained Action (pentaerythritol tetranitrate) 80 mg. is indicated for the relief of angina pectoris (pain associated with coronary artery disease). It is not intended to abort the acute anginal episode but is widely regarded as useful in the prophylactic treatment of angina pectoris.

Contraindications: Peritrate SA Sustained Action (pentaerythritol tetranitrate) 80 mg. is contraindicated in patients who have a history of sensitivity to the drug.

Warning: Data supporting the use of Peritrate (pentaerythritol tetranitrate) during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

Precautions: Should be used with caution in patients who have glaucoma.

Adverse reactions: Side effects reported to date have been predominantly related to headache (which may require discontinuation of medication) and gastrointestinal distress which are usually transient with continuation of medication.

Dosage: Peritrate SA Sustained Action (pentaerythritol tetranitrate) 80 mg., 1 tablet immediately on arising and 1 tablet 12 hours later (on an empty stomach).

Additional dosage forms
Peritrate (pentaerythritol tetranitrate)—10 mg. and 20 mg. tablets with or without phenobarbital.

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(Warning: Tablets containing phenobarbital may be habit forming.)



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**BLOOD
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Establish and maintain early, more decisive control of blood pressure

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Cryptenamine 1.0 mg.* Methyclothiazide 2.5 mg. Reserpine 0.1 mg.

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DIUTENSEN-R is thiazide and reserpine *plus* cryptenamine — a rational, comprehensive therapy to help establish and maintain early, more decisive control of blood pressure.

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“...quite apart from the problem of vascular damage, there arises a possibility of virtual ‘cure’ or remission of hypertension when treatment is early, i.e., before too many other secondary pressor systems have entered into the disequilibrium of pressor control, and when it is adequately suppressive.”

Corcoran, A. C.: The choice of drugs in the treatment of hypertension. In: *Drugs of Choice* 1966-67, W. Modell, Ed., St. Louis, C. V. Mosby Company, 1966, p. 417.

Indications: DIUTENSEN-R may be employed in all grades of essential hypertension.

Dosages: Usual dose is 1 tablet twice daily, at morning and evening meals.

However, adjustment of dosage to suit individual circumstances may be required. Please refer to package insert for full particulars. **Side effects and precautions:** The side effects observed with patients on DIUTENSEN-R have been of a mild and nonlimiting nature. These include occasional urinary frequency, nocturia, nasal congestion, muscle cramps, skin rash, joint pains due to gout symptoms and nausea and dizziness which have been reported for the individual components. Most of these symptoms disappear while the drug is continued at the same or lower dosage level. The concomitant use of digitalis and DIUTENSEN-R may increase the possibility of digitalis-like intoxication. If there is evidence of myocardial irritability (extrasystoles, bigeminy or AV block), dosage of DIUTENSEN-R should be reduced or discontinued. Nocturia in patients with marginal cardiac status and salt and fluid retention can be effectively controlled by limiting the time of administration to early afternoon. DIUTENSEN-R should not be used in patients with a known intolerance to reserpine. Package inserts furnish a complete summary of recommended cautions related to each of the ingredients of DIUTENSEN-R.

*As tannate salts equivalent to 130 Carotid Sinus Reflex Units.

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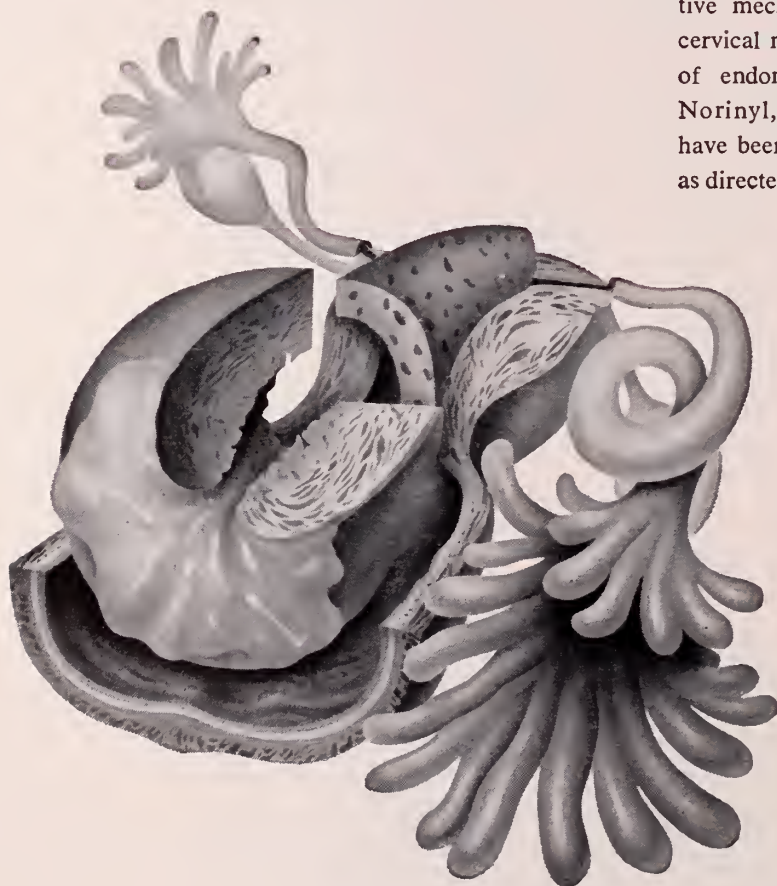
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**creation of an endometrium unreceptive
to egg implantation**

no unplanned pregnancies

Norinyl provides multiple action for maximum assurance of success. It does not depend on ovulation inhibition alone for contraceptive effectiveness. The mechanism of action of combined hormonal therapy results in ovulation inhibition reinforced by other protective mechanisms, including a hostile cervical mucus¹⁻¹³ and an acceleration of endometrial changes.^{1-3,7-16} With Norinyl, no unplanned pregnancies have been reported to date when used as directed.



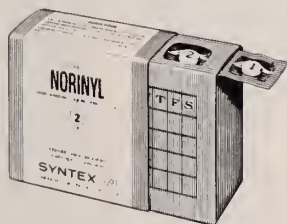
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Contraindications: Thrombophlebitis or pulmonary embolism (current or past). Existing evidence does not support a causal relationship between use of Norinyl and development of thromboembolism. While a study which was conducted does not resolve definitively the possible etiologic relationship between progestational agents and intravascular clotting, it tends to con-

firm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.

Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-

ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism. **Side Effects:** Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: 1. Council on Drugs. JAMA 187:664 (Feb. 29) 1964. 2. Bryans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. 3. Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. 4. Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. 5. Hammond, D. O.: Ibid. 6. Rice-Wray, E.: Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. 7. Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. 8. Kampers, R. D.: GP 29:88 (Jan.) 1964. 9. Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. 10. Rudel, H. W., Martinez-Manautou, J., and Maguoro-Topele, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. 11. Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964. 16. Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

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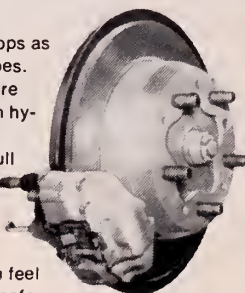
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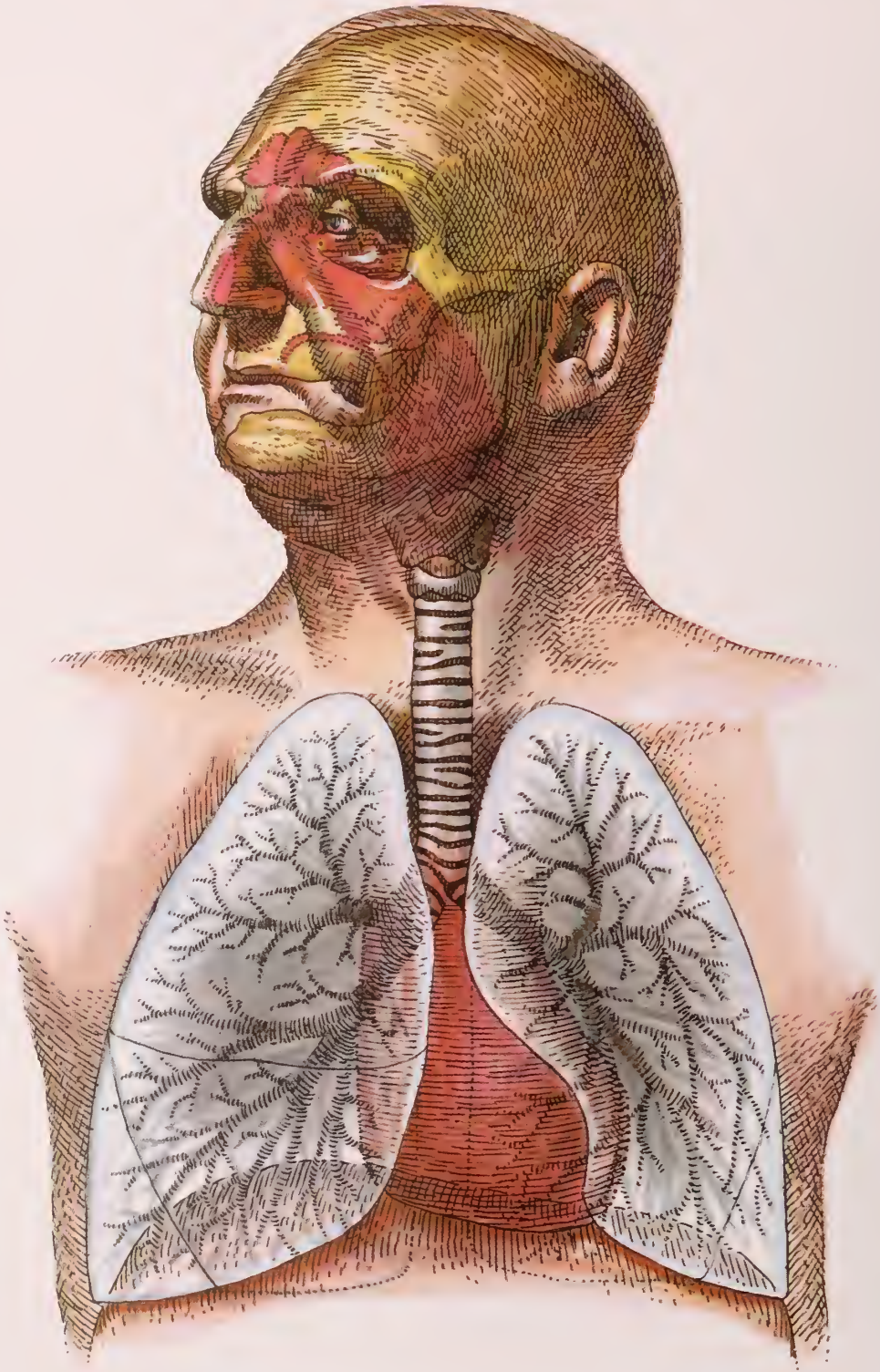
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this issue: the common cold and the aging patient

the common cold and the aging patient

Louis J. Vorhaus, II, M.D., F.A.C.P.



G. SCHWENK

Effects of aging on the anatomic and physiologic aspects of the respiratory apparatus.

The chest becomes more fixed, less mobile and less elastic as the bronchial walls and thoracic ligaments lose elasticity. The diaphragm and intercostal muscles atrophy and weaken. The lungs become smaller, flabbier and weigh less, decreasing vital and total lung capacity, increasing residual volume and the alveolar dead space.

Sir William Osler described pneumonia as the welcome friend of the aged patient, because the patient with pneumonia usually died quietly. But today, the well-informed physician is an even better friend of the aging patient, since it is better to live than to die, no matter how quietly.

One of the first avenues of approach in the control of the hazards of respiratory disease in the aging patient is prompt and proper attention to the common cold or upper respiratory infection. The common cold may be the first step in the relatively short path to lower respiratory infection, broncho-pneumonia and death. This train of events occurs frequently among older persons. Indeed, pneumonia is one of the most common causes of their admission to hospitals and ranks high on the list of geriatric killers. Colds are more debilitating in elderly people and the aged are more likely candidates for secondary infections such as sinusitis and bronchitis. These infections, in turn, are more prone to lead to broncho-pneumonia, because of lowered resistance and anatomic and physiologic changes in the lungs of the elderly.

What is different about the respiratory tree of an aged person and that of an otherwise healthy younger adult? Aging certainly takes its toll on all parts of the body, affecting both anatomic and physiologic aspects of the respiratory apparatus. These changes are in part due to the wear and tear that occurs over the years; the repeated bouts of respiratory infection, long exposure to atmospheric pollutants, to occupational inhalants, smoking, malnutrition, obesity, inactivity and the development of other diseases which may affect the lungs.

With the passage of years, the lungs change. They become scarred and emphysematous and lose their compliance. The whole chest becomes more fixed, less mobile and less elastic.

the anatomic changes that occur in aging render the lungs less efficient. Tests of pulmonary function in senescence show a deterioration characterized by a decrease in vital capacity and total lung capacity, an increase in residual volume and alveolar dead space. Maximum breathing capacity is reduced and uniformity of ventilation deteriorates. These problems are often aggravated by the obstructed breathing, fever and secondary infection associated with the common cold, placing an additional stress on the entire cardiopulmonary reserve.

In addition, the efficiency of a cough is below par in older persons even though they are in good health. This is partly due to the decreased respiratory excursions and distensibility of the chest wall, and partly from loss of elasticity of bronchial walls which tend to make them collapse in a cough.

The elderly patient's resistance to infection is often reduced. Nutritional deficiencies are more common in aged people. There is some evidence to indicate that their capacity to respond to stress is less efficient. Finally, there is often relatively meager symptomatic response to acute disease. The absence of obvious or dramatic clinical signs and symptoms of severe illness is particularly dangerous because, coming as it

(concluded on following page)

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does in a person whose defenses are weakened both locally and systemically, pulmonary disease may progress rapidly to irreversible stages before medical attention is sought. Respiratory infection is especially hazardous because the aged patient responds badly to hypoxia. Not only is his response to oxygen lack impaired, but the work of breathing, due to decreased compliance of the lung and increased stiffness of the thorax, is markedly augmented.

Many patients late in life are in a precarious and delicate cardiopulmonary balance which is easily decompensated from relatively minor insults such as colds and upper respiratory infections.

For all of these reasons, geriatricians long have stressed the importance of preventing respiratory insults. Today we have better ways of treating respiratory infection, improved techniques for clearing the lungs and bronchial tubes of secretions and better understanding of ways of improving ventilation. We possess a broader spectrum of antimicrobial agents including newer ones to deal with previously resistant organisms. Even so, the death rate from pneumonia is high in older people, and it is preferable to avoid the disease than to treat it. To do so, attention must be paid to the general maintenance of good health and all that implies, as well as to the prevention, elimination and treatment of associated conditions that predispose to or cause pneumonia such as chronic upper or lower respiratory infection, respiratory allergy, chronic sinusitis and exposure to inspired irritants.

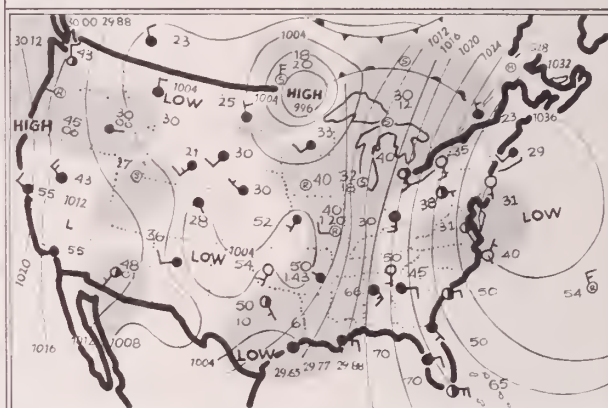
Colds and other minor respiratory infections, which favor the development of broncho-pneumonia, should be treated vigorously and promptly, particularly those patients whose aging process has been accompanied by the development of chronic pulmonary disease. Upper respiratory passages should be cleared with decongestants. Sinuses should be drained adequately. And, when indicated, appropriate antimicrobial therapy should be instituted before serious infection of the lower respiratory tree supervenes.

In decades past it was understandable that physicians welcomed pneumonia for the aged patients because it offered them a quiet and peaceful demise. Today we recognize that in many cases, peaceful as it may have been, such deaths were often avoidable. With the current knowledge and understanding of the problems that respiratory infections impose on aging people, vigilant medical attention can often

restore them to a vigorous, rewarding and productive life so that the many opportunities that exist today for people to enjoy their golden years are realized and not stolen by untimely death.

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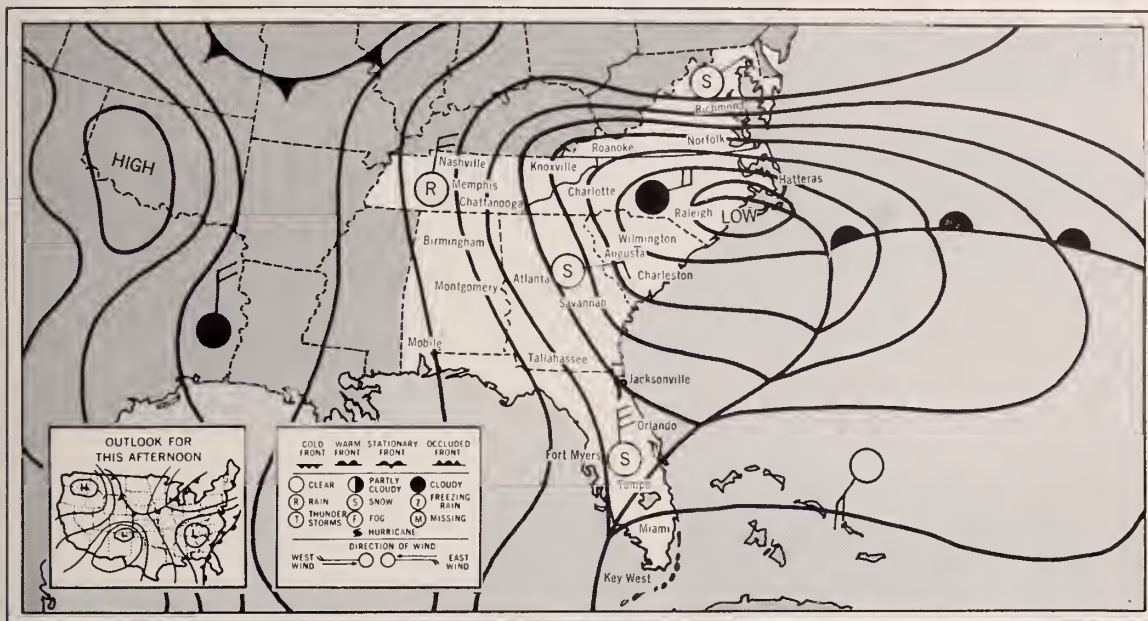
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Reference: 1. Roberts, C. E., Jr., Perry, D. M., Kuhoric, H. A., and Kirby, W. M. M. A. M. A. Arch. Int. Med. 107:204 (Feb.) 1961.

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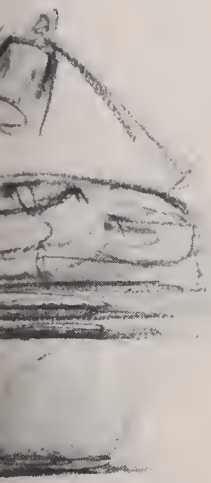
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DOSAGE: *Children under 25 pounds*—5 mg. per pound of body weight every six hours. *Children 25 to 50 pounds*—125 mg. every six hours. *Adults and children over 50 pounds*—250 mg. every six hours. For severe infections, these dosages may be doubled.

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Nephrotic Syndrome in the Adult

DANIEL M. LEVIN, M.D.

The nephrotic syndrome in adults is usually separated from that in children because the two differ in several important aspects. In general, with the nephrotic syndrome in adults, there is a greater variety of underlying diseases; impairment of renal function is frequently more severe; response to therapy is generally less satisfactory; and death in uremia is the more usual outcome.

The purpose of this review is to cover three general areas: (1) the experience here and elsewhere relating to the etiologies of the nephrotic syndrome in adults; (2) some comments on the pathologic physiology involved in the syndrome, and (3) a discussion of the therapy available for this serious condition.

In the years 1960-1964, we had full evaluation of 42 adults over the age of 13 with nephrotic syndrome (fig. 1). This group was evenly divided between men and women, confirming again that there is no sex predominance. All age groups are involved, up to patients in their 80s; there is perhaps a somewhat increased incidence in the young adult.

While the nephrotic syndrome develops in children almost exclusively either as a result of acute glomerulonephritis or because of a pure membranous lesion, or lipid nephrosis, table 1 enumerates most of the reported causes for the

syndrome in adults. In any series, one or another form of glomerulonephritis will be responsible for about two out of three cases of nephrotic syndrome; the need to learn which of these forms of glomerulonephritis is responsible in any one case will be gone into later. In all cases of glomerulonephritis, history and/or laboratory evidence of a recent beta streptococcal infection can be found in only 20 to 25% of cases; and it is usually the proliferative form which occurs as the result of poststreptococcal nephritis.

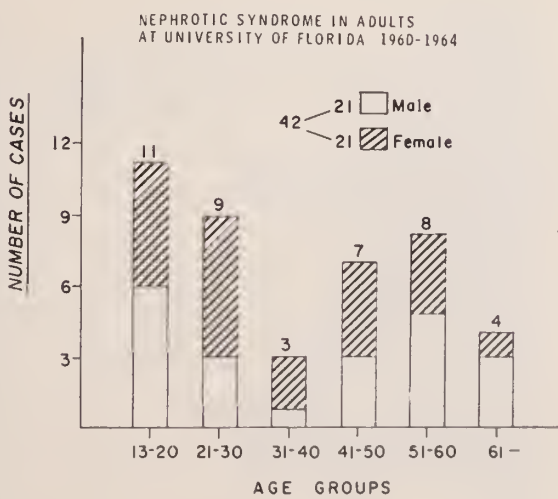


Fig. 1.—Patients over age 13 with diagnosis of nephrotic syndrome at University of Florida Hospital for five year period 1960-1964.

Assistant Professor of Medicine, University of Florida College of Medicine, Gainesville, and Veterans Administration Clinical Investigator.

Diagnosis

Patients with diabetes mellitus are unusually prone to the development of renal disease; and diabetic glomerulosclerosis, or intercapillary glomerulosclerosis or Kimmelstiel-Wilson disease—these are synonymous—is third behind arteriolar sclerosis and pyelonephritis in frequency of occurrence among patients with diabetes. It is estimated that one third of those over the age of 40 show this lesion microscopically, which is almost always accompanied by diastolic hypertension, reduced renal function, and microaneurysms in the eyegrounds. Development of this lesion in the diabetic patient is a bad sign, two thirds of the patients dying within three years of the onset of the nephrotic syndrome.

Amyloidosis, either primary or secondary, should always be considered in an adult with the nephrotic syndrome. Five to 10% of kidney biopsies will reveal amyloidosis as the underlying process. Clues to this diagnosis are: (1) nephrotic syndrome in a man over age 40, (2) a history of tuberculosis, osteomyelitis, rheumatoid arthritis, or other chronic suppurative process, (3) lack of hypertension or even the presence of hypotension, (4) lack of hematuria, and (5) the recognition of large renal shadows on x-ray. Biopsy is the only definitive diagnostic procedure for amyloi-

dosis, and kidney biopsy will yield the highest rate of positive findings. One fourth to one third of patients with multiple myeloma have associated amyloidosis and a resulting nephrotic syndrome.

The third major group is that of the systemic sensitivity, or collagen vascular diseases, lupus erythematosus being the prototype and most common of the group. Lupus occurs more commonly in women, particularly younger women, in a ratio of 4 to 1. Although 70% of all cases of lupus show evidence of renal involvement, the full-blown nephrotic syndrome develops only in about 20%. The so-called telescoped urine sediment, in which one sees evidence of acute, subacute, and chronic changes of glomerulonephritis, is characteristic of this group of diseases. Several reports have recently pointed out that patients with lupus may present with a typical nephrotic syndrome but with normal serum cholesterol and total lipid levels; this is probably because of lupus involvement of the liver along with the kidney lesion. Such a finding certainly is not pathognomonic for lupus, but may be helpful in the diagnosis.

In most series, these three groups will account for about 95% of cases of adult nephrotic syndrome; the remaining few cases will be made up of the rest of the causes listed. Circulatory diseases, by means of vascular dilatation or recurrent

Table 1.—Causes of Nephrotic Syndrome*

- | | |
|---|---|
| <ol style="list-style-type: none"> 1. Glomerulonephritis
Membranous
Proliferative
Subacute 2. Metabolic diseases
Diffuse and nodular diabetic glomerulosclerosis
Amyloidosis
Multiple myeloma 3. Systemic sensitivity diseases
Systemic lupus erythematosus
Periarteritis nodosa
Dermatomyositis
Wegener's granulomatosis 4. Circulatory diseases
Sickle cell anemia
Renal vein thrombosis
Constrictive pericarditis
Congestive heart failure
Tricuspid valvular insufficiency 5. Nephrotoxins
Organic mercurial diuretics
Inorganic mercury
Bismuth
Gold | <ol style="list-style-type: none"> 6. Allergens and drugs
Pollen
Bee stings
Poison oak, poison ivy, and rhus toxin
Tridione and Paradione
Snake bite
Insect repellants
Miscellaneous allergens and serum therapy 7. Diseases due to infection
Cytomegalic inclusion disease
Syphilis
Malaria
Typhus
Chronic jejunoileitis
Tuberculosis
Subacute bacterial endocarditis
Herpes zoster 8. Heredofamilial causes 9. Miscellaneous causes
Pregnancy
Transplant
Cyclic recurrence
Neoplasm |
|---|---|

*Strauss and Welt, *Diseases of the Kidney*, ed. 1, 1963, pp. 336-7

Table 2.—Causes of Adult Nephrotic Syndrome

Etiology	No.	%	% of 183 patients
Subacute glomerulonephritis	7 (2)	16	5
Membranous glomerulonephritis	14 (2)	33	33
Proliferative glomerulonephritis	8 (6)	19	24
Acute glomerulonephritis	1 (1)	2	10
Diabetic glomerulosclerosis	3 (2)	7	18
Lupus erythematosus	4 (2)	10	6
Amyloidosis	2 (0)	5	3
Wegener's granulomatosis	1 (1)	2	1 (misc)
Toxic nephropathy	1 (0)	2	
Renal vein thrombosis	1 (1)	2	
	42 (18)	100	100

Histological diagnoses in University of Florida series with number of patients with each diagnosis; per cent of entire series with each diagnosis; and a comparison of these percentages with those in a series of 183 patients reported from Georgetown Hospital. Numbers in parentheses represent the number in each group who have died.

ischemia, may rarely produce glomerular lesions which can develop into the nephrotic syndrome. Renal vein thrombosis is being recognized more in recent years and may develop in association with phlebitis of the lower extremities and pelvic veins, with amyloidosis, or with malignant disease, particularly carcinoma of the lung.

In table 1 the more unusual causes of the nephrotic syndrome in adults are also listed. Those listed under allergens and drugs produce a serum-sickness-type reaction with a membranous type of glomerular lesion. Some of those blamed on infection are believed to be due to secondary amyloidosis developing in the wake of a chronic process, and familial forms of the nephrotic syndrome have also been described.

Table 2 sets forth the histological diagnoses in our series of patients; the number of patients with each diagnosis; the per cent of the entire group with each diagnosis; and a comparison of these percentages with those in a series of 183 patients reported out of Georgetown Hospital. The numbers in parentheses represent the number of patients in each group who have died. The composition of the two series is similar, with glomerulonephritis accounting for two thirds of all cases; fewer cases of diabetes, lupus, and amyloid; and a scattering of other diseases. Also note the poor prognosis for diabetic nephropathy and the marked difference in the outlook for the different forms of glomerulonephritis, only two of 14 with the membranous form having died, while six of eight with proliferative glomerulonephritis are dead during the same period of follow-up.

Since a good understanding of the pathophysiology involved in the nephrotic syndrome can make for more rational therapy, a brief discussion of the physiological changes may be helpful. At the top of figure 2 one sees that the nephrotic syndrome is probably initiated by an antigen-antibody, a hypersensitivity, reaction involving the glomerulus. Our ability to reproduce the nephrotic syndrome in laboratory animals by various means of sensitization supports this concept for its etiology. As a result of this reaction, inflammation within the glomerulus leads to reduced renal function as measured by reduced renal blood flow and glomerular filtration rate.

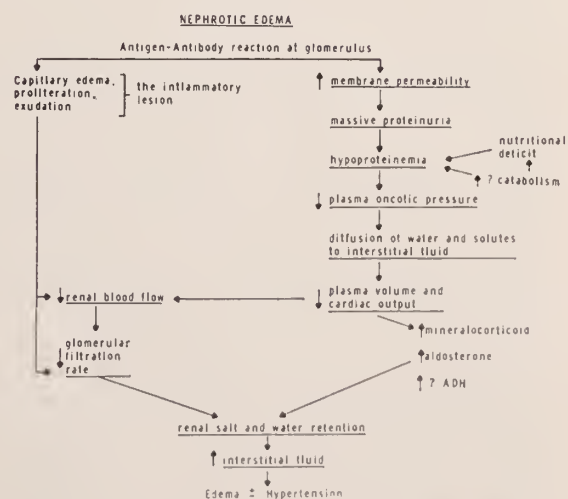


Fig. 2.—Currently most acceptable scheme for the pathogenesis of nephrotic edema. (Strauss and Weit, Diseases of the Kidney, ed. 1, 1963, p. 358).

the same time, the glomerular basement membrane is damaged and becomes much more permeable; this condition leads to one of the hallmarks of the nephrotic syndrome, marked proteinuria, up to 40 or 50 Gm. per day. Since this is merely a matter of a mechanical leak, the smaller albumin molecules are lost to a greater extent than are the larger globulin molecules, the large alpha-2-globulin being lost least of all. The marked proteinuria results in decreased serum protein levels, the characteristic pattern being an extremely low albumin and a relatively increased alpha-2-globulin level, a reflection of the urinary losses of each of the protein components. Another finding is that blood fibrinogen levels are frequently elevated; since, more and more, coagulation defects are being implicated in the reaction taking place in the glomerulus, these elevated fibrinogen levels may assume more importance in the future. In general, there is good correlation between the serum albumin concentration and the severity of edema, all patients with massive edema having albumin levels below 2.5 Gm.%. Increased catabolism and inadequate intake due to anorexia probably also contribute to the low protein levels.

The hypercholesterolemia and elevated plasma lipid levels are not completely explained, but are probably due in large part to the hypoproteinemia. Albumin plays a major role as an acceptor in the transport system required for the interconversion of large and small lipoprotein fractions; in the presence of reduced albumin levels, this rate of interconversion is not carried out properly, so that blood levels build up.

Because of a loss of protein molecules from the vascular system, the vascular system is less able to retain water and solutes, with the consequent diffusion of these into the interstitial fluid, with edema formation. As a result of this diffusion, the effective plasma volume and the cardiac output diminish, further reducing renal blood flow and glomerular filtration. The reduced volume and cardiac output, through various receptor mechanisms, stimulate increased release of salt-retaining adrenal cortical hormones and, probably, also antidiuretic hormone which, along with the reduced glomerular filtration rate, cause increased renal reabsorption and retention of salt and water. The salt and water also leak out of the vascular space, and the end result is more edema. An ap-

preciation of these mechanisms can make the treatment of the nephrotic syndrome more meaningful.

Complications

Patients with nephrosis are particularly susceptible to infections; this susceptibility is probably related to their protein deficiency and should be kept in mind always, especially in regard to use of indwelling catheters. Second, in about two thirds of nephrotic patients, hypertension develops, both as a result of intrinsic renal disease and because of increased salt and water retention. It should be treated with the usual measures, except that diuretics should be used cautiously. Third, these patients generally do not feel well and eat poorly; it is difficult to maintain adequate nutrition, but the use of high protein diets is of no benefit and should not be tried. Fourth, the occurrence of thromboembolic complications is being recognized more and more in the nephrotic patient. In our series, three such episodes occurred, two requiring amputation of extremities. Others have reported thrombosis of the main pulmonary artery and the anterior tibial syndrome as other examples of thrombotic complications. Numerous factors probably contribute to this thrombotic problem—the high serum lipids; the increased fibrinogen levels; the reduced plasma volume; increased blood viscosity; inactivity, and others.

Treatment

Therapy usually follows two broad approaches. Since the edema is usually the most troublesome symptom for the patient, most of our therapeutic efforts have been aimed in this direction. Non-specific measures used to reduce the edema include: (1) bed rest, which will tend to promote diuresis; (2) restriction of dietary salt intake to 1 or 2 Gm. per day and of fluid intake to 500 to 800 ml. per day, in an attempt to counterbalance renal salt and water retention, (3) diuretics which may be of benefit to reduce salt and water reabsorption by the kidney and to reduce the effects of the various hormones. Several points, however, should be kept in mind if they are used. One should be aware that it is almost impossible to achieve diuresis with any agent when the serum albumin is less than 1.5 Gm. %; that patients

Table 3.—Clinical Comparison of Various Histological Forms of Glomerulonephritis

	Membranous	Proliferative	Mixed
Urine protein	>6.0 Gm.	<6.0 Gm.	Features of both
Hematuria	Mild ($<3.0 \times 10^6$)	Marked ($>3.0 \times 10^6$)	
White cells	Mild ($<3.0 \times 10^6$)	Moderate ($>3.0 \times 10^6$)	
Hypertension	Usually absent	Frequently present	
Azotemia	Late	Early	
Clinical course	Benign until late	Early difficulty	

with azotemia have an impaired response to any diuretic program; and that mercurials can induce acute tubular necrosis and should be used with caution in the nephrotic syndrome. To continue with the general measures, (4) we attempt to increase the intravascular volume by infusing concentrated albumin or other plasma expanders. One gram of infused albumin can mobilize 21 ml. of edema fluid. One group reports rendering five of 13 patients edema-free by infusing 50 Gm. of albumin per day for four or five days. Unfortunately, this measure is costly, and the relief transient. (5) High protein diets, as mentioned previously, are of no benefit, and, in the face of azotemia, can be harmful. (6) Since this is a hypersensitivity disease, immunizations and skin testing probably ought to be avoided during the period of active disease.

The other broad approach, and certainly a more rational one than just the symptomatic treatment of the edema, is a direct attempt to stop or block the antigen-antibody reaction taking place in the glomerulus. To do so, we have had experience with three types of drugs: (1) the steroids; (2) various agents which tend to knock out the reticuloendothelial system; and (3) heparin. Before one decides to begin treatment with any of these, however, and they should be started early, it is vital that a tissue diagnosis by means of kidney biopsy be established. A diagnosis is important because steroids, the usual treatment, should not be used indiscriminately. Steroids are contraindicated in diabetic glomerulosclerosis; they are potentially harmful in amyloidosis; and they also appear to accelerate the course of proliferative glomerulonephritis. If there is an indication for the use of steroids, it appears to be in pure membranous glomerulonephritis, particularly if there is little or no change under the light microscope.

Because glomerulonephritis is the commonest cause of the nephrotic syndrome and because the different forms of glomerulonephritis respond so differently to treatment, it is helpful to be able to recognize the various forms clinically. Table 3 gives a clinical comparison of membranous and proliferative glomerulonephritis. In general, the membranous form shows much protein, more than 6 Gm., with few cells, less than about three million, and a mild course as compared to the proliferative form, which shows many cells with relatively little protein and a more rapid course. There is also a mixed form which shows elements of both.

For membranous glomerulonephritis and perhaps for lupus, steroids are usually recommended, beginning with a dose equivalent to 60 mg. per day of prednisone and tapering as a response is obtained. There has been some evidence lately that side effects of hypercorticism and adrenal gland suppression can be greatly minimized by giving the prednisone intermittently in doses of 120 to 150 mg. at a time three times per week rather than on a three or four times a day schedule. Whereas more than 50% of children will respond to steroids, only about 20% of all adults with nephrosis will respond. At this institution, we have had no success in treating lupus nephritis with steroids; so that for lupus and proliferative glomerulonephritis, we have been using two experimental programs—Imuran and Heparin. Imuran is a new analogue of 6-mercaptopurine, another antimetabolite which has also been used in the treatment of these conditions. Heparin is being used because of its anticoagulant effect—we have already mentioned the elevated fibrinogen and clotting abnormalities occurring in glomerulonephritis—and because of its anticomplementary action, complement being necessary for the antigen-antibody reaction. Heparin has been shown to

block well the production of experimental glomerulonephritis in animals. We have treated about a dozen patients with these drugs using about 1 mg./kg of Imuran daily or 200 mg. of long-acting heparin every 18 to 24 hours, and initial results, not in a controlled study, are encouraging. There is no treatment as yet for diabetic nephropathy or amyloidosis.

Table 4 shows that 18 of 42, or 43%, of these patients are now dead, within five years of diagnosis, pointing up, again, the poor prognosis in the adult nephrotic syndrome.

With the knowledge which has been accumulated about the nephrotic syndrome and with the potent new immunosuppressive agents which are available, it is more important than ever for this

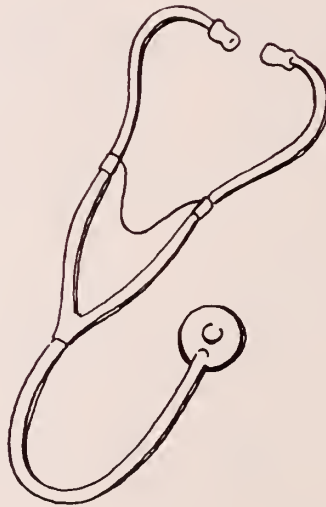
Table 4.—Five Year Survival in University of Florida Series

Total	42
Still living	24 (57%)
Dead (1 Suicide)	18 (43%)

condition to be diagnosed and properly treated as early as possible. Only in this way can its sequelae be prevented and its poor prognosis improved.

References are available from the author upon request.

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Varicose Vein Surgery in the Immediate Postpartum Period

WILLIAM H. HARRISON JR., M.D., THOMAS L. WELLS, M.D.,
CHARLES STUMP, M.D. and O. B. BONNER, M.D.

Of all the complications of pregnancy, the development of venous varicosities, though not the most serious,¹ is perhaps the most common. Between 15 and 20% of patients suffer from symptomatic venous varicosities during their pregnancy.² Although in the past conservative management throughout pregnancy followed by delayed vein stripping procedures weeks or months later has been the most common form of treatment, there are those who recently have reported excellent results in varicose vein surgery in the immediate postpartum period.¹⁻⁴ Several factors influence the development of venous varicosities during pregnancy, and with repeated pregnancies the situation worsens. Total blood volume is increased and with the steady growth of the uterus, mechanical pressure on the iliac veins gives rise to increased venous pressure in the lower extremities.^{5,6} Wright,⁷ using radioactive sodium, showed that the venous blood flow from the foot to the groin is slowed during pregnancy. Nabatoff⁸ thought that hormonal changes occurring during pregnancy, causing vasodilatation, are responsible for varicose veins developing most commonly at this particular time of life.

In the nonpregnant state a patient with venous varicosities frequently gives a family history of varicosities. These usually result from (1) saphenofemoral insufficiency, (2) short saphenous popliteal insufficiency or (3) incompetent perforators.²

Mullane¹ has been performing surgery for varicose veins for years, operating on the fourth or fifth day postpartum. Our particular series of 21 stripping procedures on 13 patients supports the findings of Keith (40 patients),³ Snyder and Crumrine (27 patients)⁴ and Wilson² showing that excellent results can be obtained in perform-

ing surgery on varicose veins in the immediate postpartum period.

Indications for Surgery

All patients presenting themselves for surgical evaluation are considered individually. It is imperative that they give a history of significant venous varicosities before the present pregnancy since often following the first pregnancy the veins will become insignificant as the blood volume returns to normal and the pressure of the enlarged uterus on the iliac veins disappears. With repeated pregnancies, however, or with symptomatic venous varicosities by history between pregnancies, the patients are evaluated during their third trimester for vein stripping following delivery. At this time the expected results are explained to the patient as well as the indications for performing surgery.

Following delivery the patients are re-evaluated. If surgery is still indicated, as soon as the patients are permitted to stand, the involved lower extremities are scrubbed early with a hexachlorophene solution and the varicose veins are marked with gentian violet. In addition, frequently the lines of incision are also marked.

Surgical Technique

After the gentian violet is dry, depending upon when it is feasible, the patient is taken to the operating room for operation. This is usually between 24 and 48 hours following delivery.

The greater saphenous vein is removed first by making an incision in the groin and ligating the external pudendal, the superficial epigastric, the superficial circumflex iliac and the lateral femoral veins. All veins of sufficient size that can be stripped by either the intraluminal or extraluminal strippers are also stripped as far as possible. An intraluminal stripper is then passed from an incision made in the ankle up the greater

From the surgical service of Halifax District Hospital, Daytona Beach.
Read before the Florida Medical Association, Ninety-Second Annual Meeting, Hollywood, May 13, 1966.

saphenous vein to the groin and the entire greater saphenous vein is avulsed. Numerous other previously demarcated areas are likewise avulsed by making incisions over the enlarged veins, dissecting as much as possible bluntly with Kelly clamps, grasping these veins and avulsing them. Bleeding is easily controlled by pressure and has been no problem. It is most important to be thorough and to make as many incisions as necessary over the communicant veins so that the postoperative recurrence of such veins is less likely.

All incisions are made transversely and the greatest cosmetic result is thus obtained as these incisions do not tend to spread in time where longitudinal incisions on the leg will spread and be more noticeable.

The patients are followed postoperatively for a period of one year and at the end of six months small spider type veins will sometimes be injected with sodium tetradecyl sulfate with benzyl alcohol or larger veins will be avulsed in the office under a local anesthetic. Patients are again seen at the end of one year and this procedure, if indicated, is repeated.

It is important to explain to the patient that even though the most thorough stripping procedure possible is used, chances are likely that some communicants will appear in the future and that these will have to be dealt with at that time for best results.

Following the surgical procedure, the patients are allowed to stand as soon as they have recovered from the anesthetic, usually late that evening or early the next morning. They are allowed to return home whenever the obstetrician would normally allow them to be discharged following their delivery. Thus increased hospitalization beyond that normally used for delivery is avoided. It is our opinion that patients feel better the day following their stripping procedure than they do the day before.

The age range in our patients was from 27 to 39 with the average being approximately 33 years. All of these patients had completed at least one prior pregnancy and one patient had completed 10. The length of hospitalization following surgery varied from two to five days with the average being three days. All of the patients operated upon had moderate to marked varicosities. Five of the patients had unilateral stripping procedures

since only one leg was involved and the majority (eight) had both legs operated upon.

There were no complications in any of these patients with the exception of one superficial cellulitis which occurred after the patient had returned home and cleared promptly on antibiotic and heat treatment at home.

Of great significance is the fact that in five (38%) of these patients superficial thrombosis had already developed in these varicose veins even though they were operated upon 24 to 48 hours postpartum. Excessive hospitalization of these patients was thus avoided because these veins, including the thrombi, were all avulsed at the time of operation and also the possible postoperative complications of pulmonary emboli or propagation and deep vein thrombosis were thus avoided. Quattlebaum⁹ reported that in one third of his patients with venous varicosities in pregnancy thrombophlebitis developed and some had pulmonary emboli.

Summary

Experience in performing 21 stripping procedures on 13 patients in the immediate postpartum period is presented. The following advantages are described.

A more thorough stripping procedure can be performed because the veins are still somewhat distended and the communicants can be identified and avulsed more readily. This minimizes the likelihood of recurrence of communicants in the future with subsequent pregnancies in later life.

Performing the procedure at this time has proved to be safe and it has the advantage of preventing hospitalization in the future thus eliminating additional hospital costs.

Most important is that this procedure minimizes the possibility of postpartum phlebothrombosis and the likelihood of propagation into the deep veins and phlegmasia alba dolens or pulmonary emboli. Should superficial phlebothrombosis already have occurred, it is early and minimal and the vein stripping can still safely be performed.

References are available from the authors upon request.

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Current Status Of Uterine Cytology In Florida

JAMES B. HUTCHESON, M.D.

In June 1964, the physician members of the Cytology Committee of the American Cancer Society, Florida Division, met to discuss the current status of cytology in the state and to determine whether or not additional emphasis need be placed on public and professional education in uterine cytology. In an effort to obtain information pertaining to the use and availability of Pap tests, and the attitude of clinicians and pathologists toward these tests, the committee drafted a questionnaire which was mailed to physicians listed as practicing general surgery, internal medicine, general practice, obstetrics and gynecology and pathology. The completed forms were identifiable by specialty but were unidentifiable by name unless the physicians voluntarily signed them. I have taken the liberty of interjecting some personal thoughts in appropriate paragraphs to expand the ideas developed in the analytical presentation of the questionnaire and to emphasize significant points known to be representative of current medical opinion.

It is thought that this survey is of unusual significance because the answers to the questions are those of a statewide population of practicing physicians based on their individual, practical experience in the day to day management of patients in whom carcinoma of the cervix has or may develop.

In October 1964, 1,775 forms were mailed out and within one month 882 had been returned (table 1). In view of the length of the questionnaire we were agreeably surprised by the high percentage of returns from physicians in all categories and the over-all average return of 50%. A few of the returned questionnaires were not included in the survey because of retirement or relocation of the physicians. International Business Machine cards and computing equipment were used to analyze the results of the questionnaire. The promptness of the returns and the many hand-written comments indicated a great interest in the subject.

A significant number of physicians in all groups would attend local and state seminars in cytology (table 2). As a result of this response several programs are being planned.

Over 90% of all groups recommend an annual motivational program to encourage more women to have vaginal cytologic examinations, and a somewhat smaller percentage would participate in such a program (table 3). This enthusiastic response has led to plans for a Florida-wide, local option, continuing, largely self-supporting cytology program sponsored by the American Cancer Society, Florida Division, and cosponsored by the Florida Society of Pathologists. Emphasis is to be placed on the high risk group of women who have never had a diagnostic cytologic examination and women who are not having the Pap test on a regular basis. This program is intended to complement the programs of the Florida State Board of Health in uterine cytology.

Director of Pathology, Tampa General Hospital, Tampa.
This project sponsored by the American Cancer Society, Florida Division.

Exhibited at the meetings of the Florida Medical Association, Bal Harbour, Fla., April 22-25, 1965; American Society of Clinical Pathologists and College of American Pathologists, Chicago, Ill., Oct. 18-21, 1965, and American Society of Cytology, New York, N. Y., Nov. 4-6, 1965.

CYTOLOGY QUESTIONNAIRE OCTOBER 1964

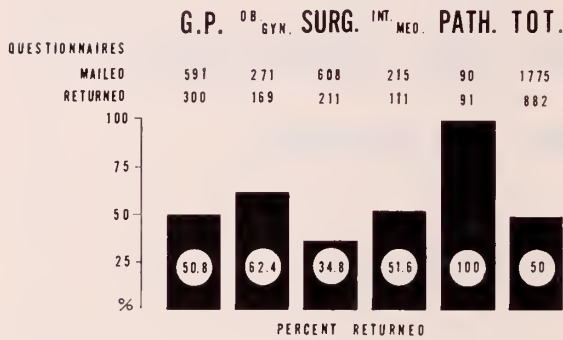


Table 1.—Number and Percentage of returned Questionnaires

I WOULD ATTEND CYTOLOGY SEMINARS

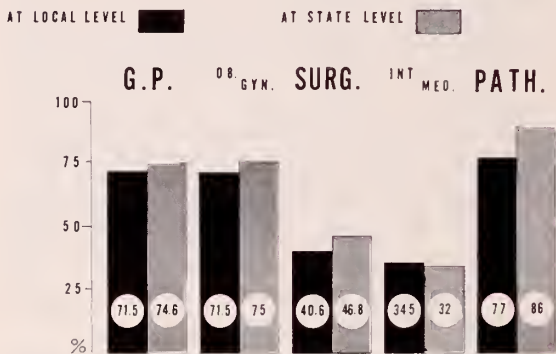


Table 2.—Physicians' Interest in Seminars on Diagnostic Cytology

I RECOMMEND AN ANNUAL CYTOLOGY PROGRAM



Table 3.—Physicians' Recommendation for an Annual Cytology Program

Almost all physicians responding recommend the collection of material from the cervix alone or the cervix and vagina (table 4). Vaginal fluid is useful for cytohormonal studies or the occasional detection of tumors originating in the endometrium, fallopian tubes, or ovaries. A majority in all groups favor collection of material from the cervical os and the posterior fornix of the vagina. A major preference for the use of the spatula alone or with a swab in the collection of specimens for cytologic evaluation was indicated (table 5). Endocervical aspiration is useful in selected cases. The swab alone is least desirable as cells become entrapped in the fibers, resulting in a scanty cell spread often inadequate for examination.

Answers to the question dealing with average number of cytology specimens collected revealed a wide range of variation within the various groups of doctors and between the groups (table 6). The general averages, however, indicate the need for a higher number of specimen collections.

The gynecologists' interest in and dependence upon the Pap test are indicated by the high percentage who obtain Pap tests in all of their adult female patients (table 7). The general average from all categories is 56%. *The main indication for a Pap test should be the absence of all symptoms and signs of uterine disease. In a patient with a visible lesion of the cervix or vagina, the physician should obtain a biopsy, preferably together with a Pap test.* Reliance on the Pap test alone in the presence of a visible lesion is to be strongly discouraged. Until such time that Pap tests are performed on a routine basis in conjunction with every general physical examination, cases of curable carcinoma of the cervix will go undetected.

Answers to the question concerning the recommended interval for a repeat examination following a negative or Class I cytology report included many written-in answers (table 8). Over two thirds of all groups obtain Pap tests annually. They are obtained biannually by many physicians for women over 35 or 40 years of age. After repeated annual Class I determinations, some physicians obtain Pap tests semiannually in younger patients. Several large scale research cytology surveys have shown in situ or invasive carcinoma in approximately 1% of adult women at the time of their first cytology examination, with variations

I COLLECT OR RECOMMEND COLLECTING MATERIAL FROM:

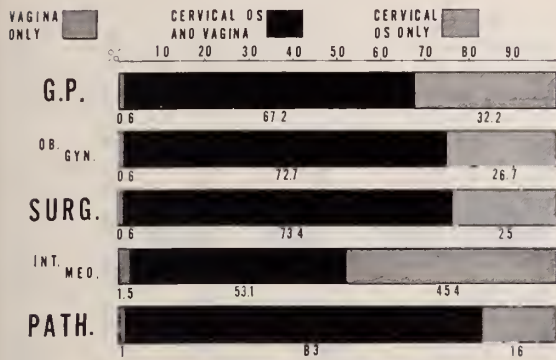


Table 4.—Recommended Site of Collection of Cytologic Specimen

FOR UTERINE CYTOLOGY I RECOMMEND THE USE OF

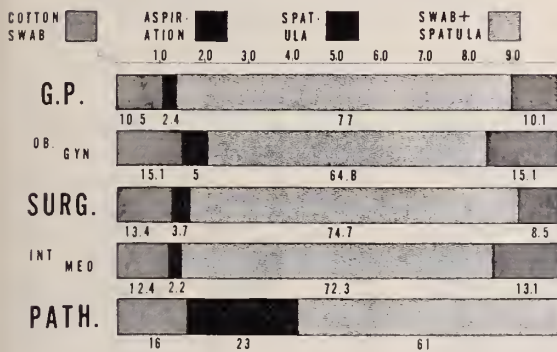


Table 5.—Instruments used for the Collection of Specimens

among the different socioeconomic groups. After two consecutive annual Pap tests this percentage drops to about 0.1 per cent and remains at this level thereafter.

Most pathologists regard a Class II report as indicative of "benign atypical changes." The clinician should be familiar with his pathologist's evaluation of a Class II report so that he will know whether to obtain a repeat smear immediately, at the next visit or within six months. He should also be guided by the physical appearance of the cervix, the age and cooperativeness of the patient and the presence of trichomonas infestation. Almost all physicians agree that some significance should be attached to the Class II report (table 9), although a great majority do not obtain biopsies on the basis of an isolated Class II report.

Class III reports are regarded by most Florida pathologists as "suspicious," but they are almost equally divided as to whether to repeat the cytologic test or obtain tissue biopsies (table 10). Pathologists will frequently suggest a repeat test or biopsy depending on the quality and quantity of cytologic changes in a Class III smear. The largest group of gynecologists and surgeons proceed with a cold conization of the cervix and D&C following a Class III report. The answers to this question indicate a mandate to the attending physician to follow up his patient when he receives a Class III report. In some studies pre-invasive or invasive carcinomas of the cervix are found to be the cause of Class III reports in as high as 50% of cases. More emphasis should be placed on the use of a Schiller's iodine test at the time biopsies are taken. Gynecologists, because of their superior knowledge of female pelvic anatomy, routinely obtain biopsy material from the squamocolumnar junction of the cervix, the site of origin of almost all carcinomas of the cervix. Biopsies obtained by other physicians are often not representative because they fail to sample this critically important area in their punch

THE AVERAGE NUMBER OF CYTOLOGY SPECIMENS COLLECTED ANNUALLY

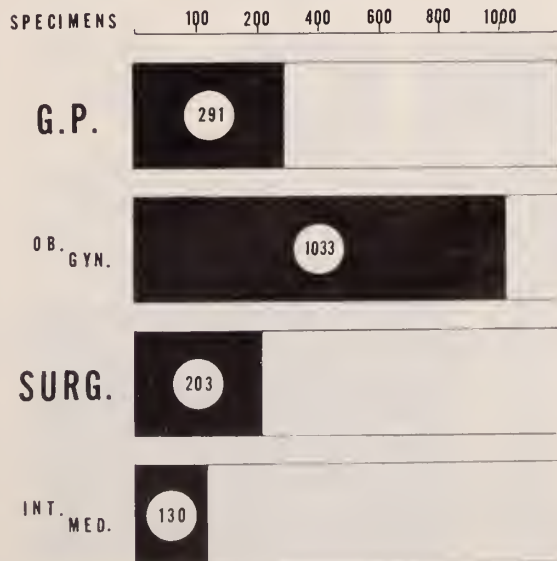


Table 6.—The Average Number of Specimens Collected Annually

biopsies and cones. Fortunately, the cautery technique of obtaining biopsy material has been virtually discarded.

When the physician is rendered a Class IV or V report, 82% of Florida pathologists recommend immediate cold conization and D&C or cervical biopsies, as pathologists interpret Class IV and Class V to indicate "probably malignant" or "malignant" changes respectively. The clinicians who perform pelvic surgery agree with the pathologists' recommendations (table 11). The small group who perform a hysterectomy with a Class IV or V change are not acting in the patient's best interests. A hysterectomy should never be performed without antecedent cold conization or punch biopsies of the cervix to determine by a tissue examination whether epithelial dysplasia, carcinoma in situ, or invasive carcinoma is causing the cytologic abnormalities. The pathologists were questioned as to their technique of examining specimens from cervical biopsy or conization when performed because of a suspicious or positive cytology report. Ninety-one per cent answered that they routinely embed and study microscopic sections from the entire specimen.

Physicians who practice obstetrics prefer to obtain Pap smears during the prenatal period or at the six week postpartum visit (table 12). Most pathologists believe that the prenatal period is the optimal time for Pap tests as cellular aberrations will be accentuated during pregnancy. Also, the atypical changes sometimes accompanying the reparative process after delivery will interfere with

I OBTAIN UTERINE CYTOLOGY SPECIMENS FROM:

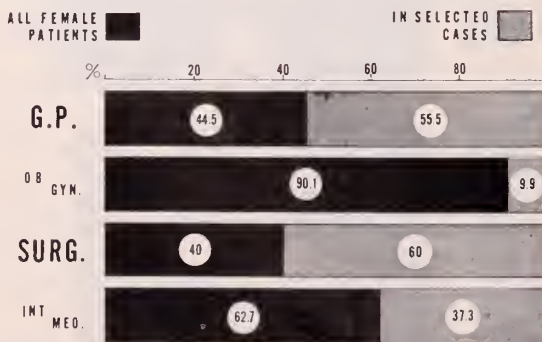


Table 7.—Cytology Tests Obtained on All or Selected Females

GIVEN A CLASS I REPORT I OBTAIN ANOTHER SPECIMEN:

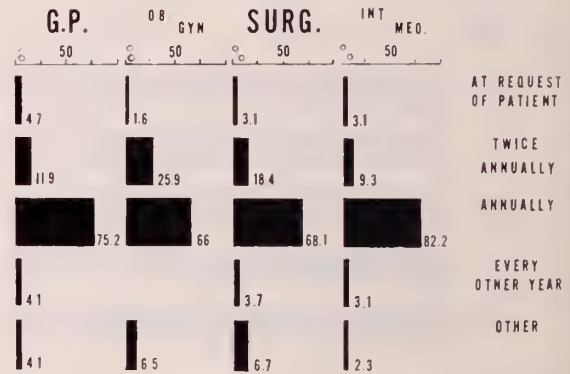


Table 8.—Physicians' Response to Negative Cytology Report

GIVEN A CLASS II REPORT, I

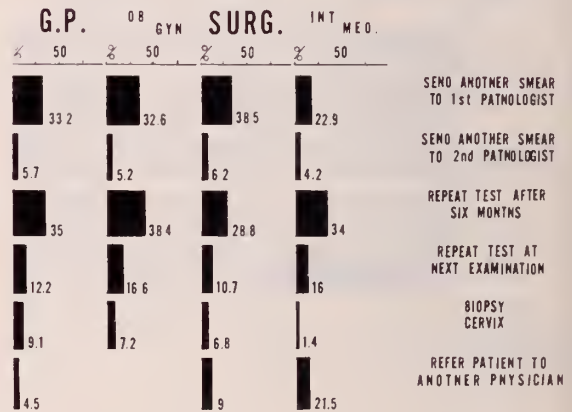


Table 9.—Physicians' Response to "Atypical" Cytology Report

the cytologic interpretation at the six week postpartum visit.

Physicians were questioned as to the approximate percentage of their patients who had heard of the Pap test (table 13). The percentage obtained by averaging all groups is 72%. This is slightly lower than the 77% obtained in a Gallup Poll conducted in 1963. In the same poll only 48% of American women indicated that they had ever had the test at least one time. These answers show that a great deal more needs to be accomplished in the area of public education so that all female adults become

GIVEN A CLASS III REPORT, I

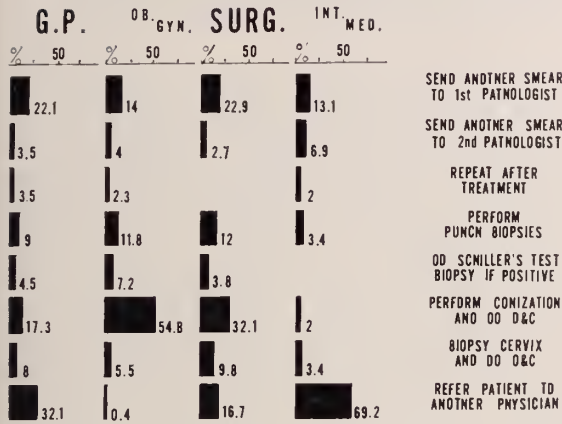


Table 10.—Physicians' Response to "Suspicious" Cytology Report

GIVEN A CLASS IV OR V REPORT, I

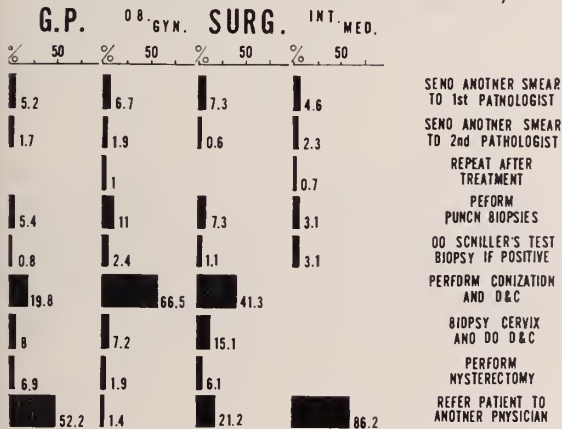


Table 11.—Physicians' Response to "Positive" Cytology Report

familiar with the test and as many as possible will be motivated to have the test performed at regular intervals. More emphasis needs to be given to educational and motivational studies in the indigent and near indigent categories of women, as it is among these women that the death rate from cancer of the cervix is the highest and the diagnostic cytologic rate is the lowest. More studies are needed to develop coordinated programs utilizing the services and talents of organized medicine, welfare and public health agencies and voluntary health groups so that the death rate from cancer of the cervix among low income

and poorly educated women can be reduced. It is a universally accepted medical fact that debility and death due to cancer of the cervix, one of the commonest killers of the adult female, could be virtually eliminated by periodic screening tests utilizing the conventional Pap smear technique.

Answers relating to the percentage of patients who resist the physician's recommendation for a Pap test reveal that the gynecologists seem to be somewhat more persuasive than their colleagues (table 14). The percentage of resistive patients was low in all categories, and the figures show that about 90% of all patients would consent to this examination. This percentage is in contrast with the general 56% average now being collected (table 7), and suggests that physicians are not recommending Pap tests to many of their patients who would submit to the test with their doctor's recommendation.

The physicians in clinical practice express overwhelming satisfaction with the pathologists' activities in cytology in regard to accuracy, professional fees and the speed of reports, percentage of Class II reports and the incidence of false-negative and false-positive results (table 15). Pathologists realize their key role as consultant to the

IN MY OBSTETRIC PATIENTS I OBTAIN PAP TESTS

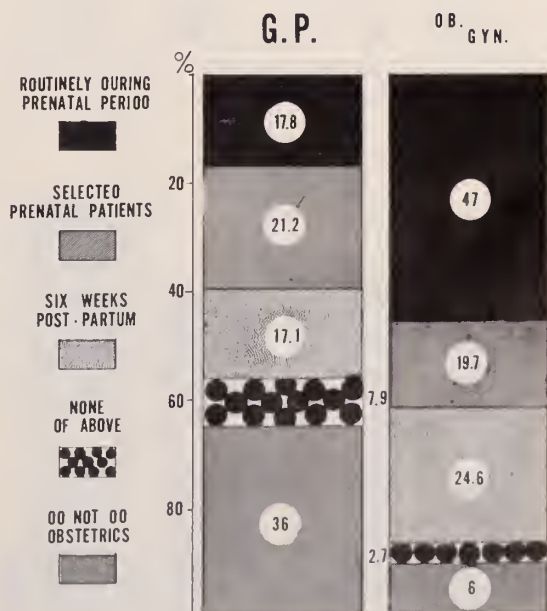


Table 12.—Pap Tests in Obstetric Practice

THE PERCENTAGE OF MY PATIENTS WHO HAVE HEARD OF THE PAP TEST:

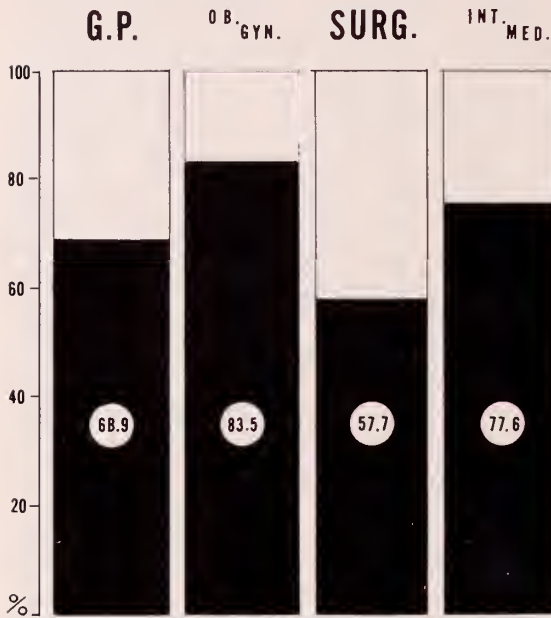


Table 13.—Percentage of Patients Familiar with the Pap Test

THE PERCENTAGE OF MY PATIENTS WHO RESIST MY RECOMMENDATION FOR A PAP TEST:

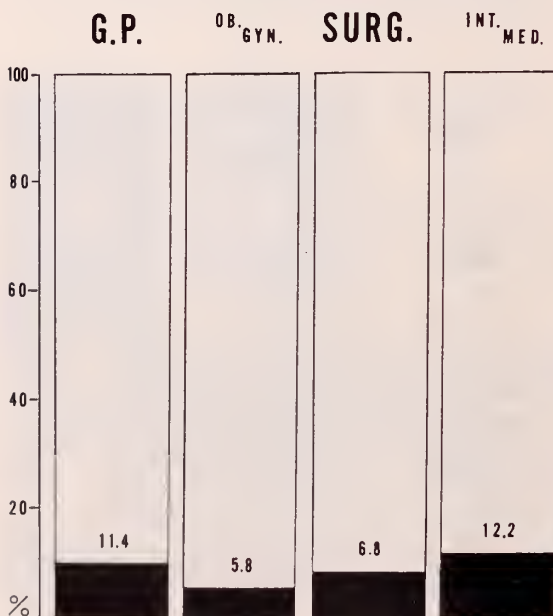


Table 14.—Patients Resistive to Pap Test

referring physician and feel a distinct responsibility to the patient with whom they have no direct personal contact.

Gynecologists again demonstrate their familiarity with gynecologic cancer by obtaining a Pap test prior to elective hysterectomy in 98.8% of all cases (table 16). Similarly a great majority of general practitioners and surgeons obtain pre hysterectomy Pap tests. Cytology can detect preinvasive or invasive carcinoma of the cervix and can suggest the possibility of pregnancy. These conditions would modify the operative plan, so that a Pap smear should be taken prior to every elective hysterectomy for benign disease.

The pathologist's fee to the patient for a Pap smear is illustrated (table 17). Despite the fact that the clinicians report that a majority of their patients pay less than \$5.00 as a fee to the pathologist for a Pap test, a small number indicate that the fees for this service vary from \$7.50 to \$10.00. The low averages show that fees for Pap tests are declining because of a steadily increasing volume, the standardization of techniques and the assistance of trained cytotechnologists.

The clinician's fee for the collection of a Pap specimen over and above his fee for a general physical examination is illustrated (table 18). A large number of physicians wrote in that they made no charge for collecting a Pap smear. Here again, a small percentage stated that they charged \$7.00 or more for collecting the specimen. The average fee appears to be inversely proportionate

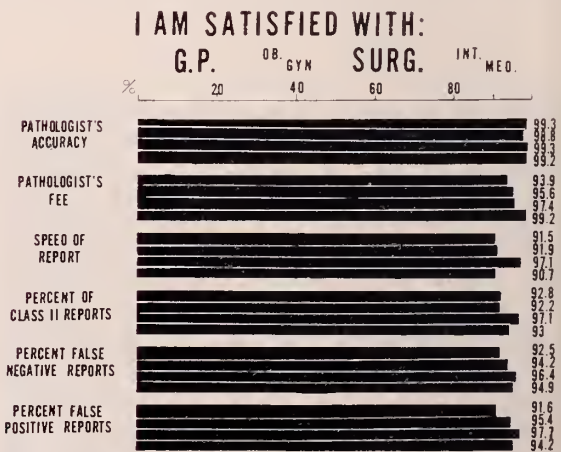


Table 15.—Referring Physicians' Evaluation of Pathologists

to the frequency with which pelvic examinations are routinely performed by the different categories of physicians.

The answers to the last question are regarded as most important as they demonstrate that a very small percentage of indigent patients cannot obtain a Pap test at a physician's private office, the outpatient department of a local hospital, the county health department or a regional tumor clinic (table 19). These answers show graphically that at this time there is no need for additional governmental subsidization for the purpose of making Pap tests more widely available to indigent patients. This adds encouragement to the hope that the proposed cytology program for Florida can be largely self-supporting. Without additional technical assistance 91% of the pathologists indicated that they could perform more cytologic examinations. While 87% of the pathologists volunteered their services to indigents at no charge if a program were initiated, 100% would expect no more than their actual costs for supplies, personnel, et cetera.

Summary

The results of a recent physicians' questionnaire on uterine cytology in Florida have been analyzed and presented. Some 888 questionnaires were returned of the 1,775 that were mailed to physicians practicing pathology, general practice,

MY FEE FOR THE COLLECTION OF A PAP SPECIMEN IS- ABOVE MY FEE FOR A GENERAL PHYSICAL EXAMINATION:

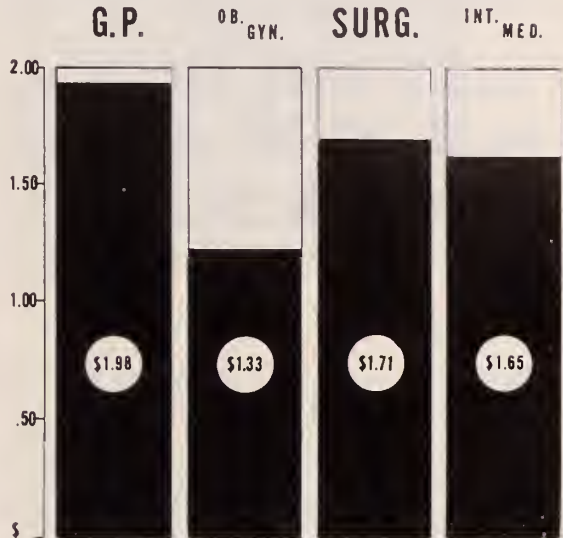


Table 18.—Fee for Collection of Pap Smear

THE PATHOLOGIST'S FEE FOR A PAP TEST IS:

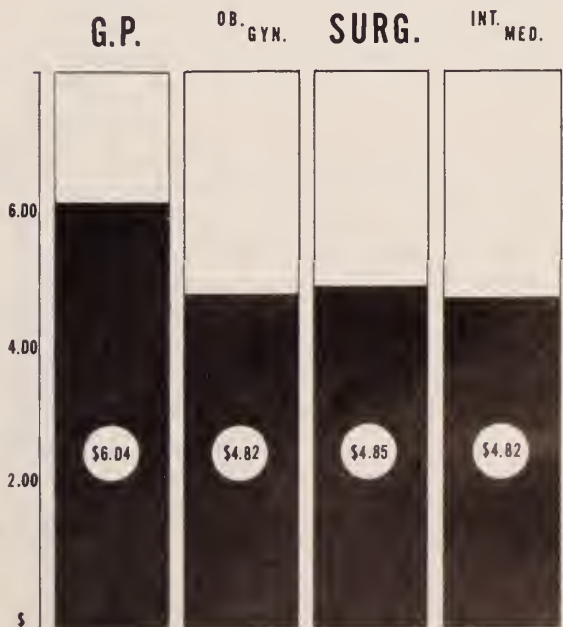


Table 17.—Pathologists' Fee for Pap Tests

PRIOR TO ELECTIVE HYSTERECTOMY FOR BENIGN DISEASE, I OBTAIN PAP TESTS ON:

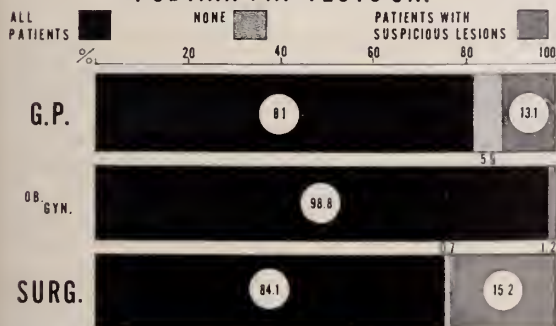


Table 16.—Pap Tests Prior to Elective Hysterectomy

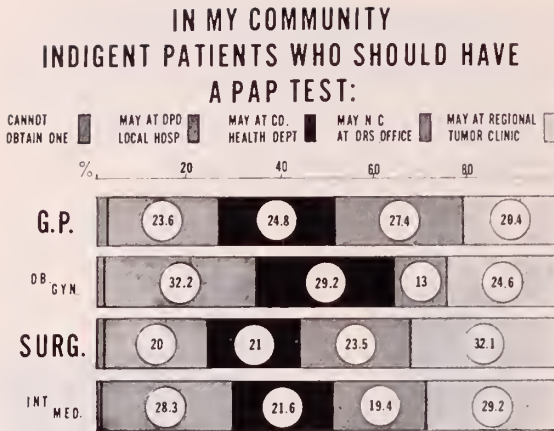


Table 19.—Availability of Pap Tests to Indigent Patients

obstetrics and gynecology, general surgery and internal medicine—a 50% return.

The high percentage of returns to this lengthy questionnaire, the written-in comments, the endorsement of the pathologist's role in cytology, the ability of 97.3 per cent of indigent women to have Pap tests at a local hospital, health department, tumor clinic or a private doctor's office, all indicate large scale professional acceptance of the Pap test as a valuable tool in the medical armamentarium to detect cancer of the cervix at an early and curable stage. Some of the answers to the questions indicate that more needs to be

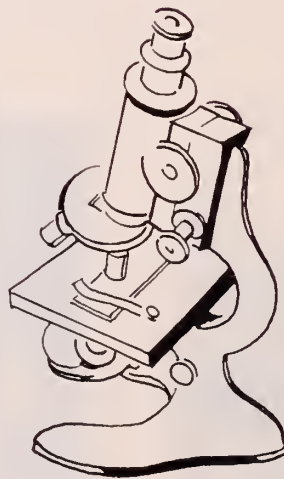
done in the area of professional education so that physicians understand that the main indication for a Pap test is the absence of all symptoms and signs of cervical disease. Furthermore, Pap tests should be obtained in all women who undergo a general physical examination, in the prenatal period of pregnancy and prior to elective hysterectomy. Hysterectomies should not be performed on the basis of suspicious or positive cytologic interpretations prior to tissue diagnosis obtained from conization or punch biopsies of the cervix.

The need for further development of public education is apparent in the fact that some female patients still resist their physicians' recommendation to have a Pap test, and only 72% of patients have heard of the Pap test.

The American Cancer Society, Florida Division, and the Florida Society of Pathologists have planned and initiated a vigorous statewide, continuing, largely self-supporting, local option, mass screening program of uterine cytology based on the answers to this survey. This program has the endorsement of the Florida Medical Association.

The author wishes to acknowledge the assistance of the Data Processing Department, First National Bank of Tampa. Mrs. Yvonne Thompson, Chief of the Histopathology Laboratory, Mrs. Lorraine Williams, Chief Cytotechnologist, and Mrs. Rosamond Hendricks, executive secretary, voluntarily devoted many hours of their time in the preparation of the exhibit and the manuscript. Mr. Robert Chapman produced the illustrations. Messrs. John Carbonneau and James Emery of the American Cancer Society provided much cooperation and assistance.

► Dr. Hutcheson, One Davis Boulevard, Tampa 33606.



The Yarmouth Castle Disaster

Further Experience in the Treatment of Large Human Burns with Aqueous Silver Nitrate (0.5%)

HIRAM C. POLK JR., M.D., and RICHARD TESSLER, M.D.

The cruise ship S.S. Yarmouth Castle burned and sank off Nassau in the early morning hours of Nov. 13, 1965. Those injured and rescued were taken directly to Princess Margaret Hospital, Nassau, Bahamas, arriving there later the same day. Although the tragedy ultimately claimed 90 lives, only five of the immediate survivors were badly burned. They were transferred to Miami the following afternoon, arriving some 40 hours after injury. From the start, the burn wounds had been treated with dilute silver nitrate solution applied upon occlusive gauze dressings. This represented the first application in a major disaster of methods previously considered primarily investigational.^{7,8}

Within recent years, largely through the efforts of a few investigators, burn research and care has turned from empiric practice to physiologic procedure. The hypotension associated with large burns, long presumed entirely due to sequestration of large volumes of both intravascular and extracellular fluid in the burn wound, has been treated with acceptable results with a variety of agents according to a maze of complex formulas. An increasing number of investigators, however, have^{5,10,11} suggested that salt-containing solutions are at least as effective as plasma, blood or the dextrans. The established basis of burn shock

was then further challenged by Moyer's observation,⁷ which we have confirmed,⁹ that in many patients clinical recovery from shock occurs while the hematocrit value continues to rise when salt solutions alone are used for resuscitation. If a plasma volume deficit is critical in the pathogenesis of burn shock, then it seems unlikely that a rising hematocrit level, indicating a falling plasma volume, would occur concomitant with recovery from shock. Although few patients die of burn shock presently regardless of the agent or formula used, the infusion of sufficient salt-containing solution to produce beneficial physiologic responses, for example, adequate urine output, does have both theoretic and practical advantages.

The hypermetabolism and cachexia often seen in survivors of large burns is another case in point. In vitro and in vivo studies have shown^{1,12} that water transfer across burned skin proceeds at rates manyfold that of normal skin. Similarly, it has been confirmed that the skin is the primary organ responsible for heat conservation. It was, therefore, appreciated, and finally confirmed in burned man as well as animals,^{2,3,9} that excessive heat and water transfer across the burn wound occurred. Evaporative water loss, of course, demands immense caloric expenditure which, like heat loss in burned mammals, is achieved at the expense of body mass. The etiologic inquiry into this hypermetabolism has more than a theoretic value for it follows that lightening of this physio-

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logic demand might favorably affect the entire burn illness. Reduction of heat and water losses has been achieved by immersion in warm isosmolar electrolyte solutions, by coverage with impermeable plastics and by thick occlusive dressings. Each method, however, has failed because infection on the surface of the burn wound has not been controlled, a number of ingenious methods and devices notwithstanding.

Currently, the most frequent cause of death in burned man is infection, usually due to *Pseudomonas aeruginosa*. While grossly insensitive to systemic antimicrobial agents, it appears that two agents for topical application can reduce the frequency and severity of burn wound sepsis. Sulfamylon cream⁴ and 0.5% aqueous silver nitrate^{8,9} both appear capable of controlling infection without adversely affecting skin regeneration or grafting. When applied to occlusive gauze bandages, and properly covered, dilute silver nitrate solution allows control of surface infection as well as reduction of heat and water losses.

Present Methods of Patient Care

Resuscitation.—As soon as the newly burned person is deemed alive, intravenous and urethral catheters are inserted and Ringer's lactate solution is infused at a rate sufficient to produce 30 ml. urine per hour. Urine flow is the primary determinant of the rate and volume of fluids infused in the first 48 hours post-burn. No agent other than commercial Ringer's lactate solution (pH 6.6-7.5) has been used. Initial determinations of hematocrit and serum sodium levels have been made to document effects of therapy, but appear to have little therapeutic value. Narcotics are used sparingly, if at all.

High humidity oxygen via mask or tent is begun for those patients burned in a confined space or about the face. Tracheostomy is discouraged unless airway obstruction exists. When nausea and emesis occur or when very large burns have been sustained, nasogastric siphon drainage is employed for 24 to 48 hours. The intravenous infusion is continued for 48 hours, at which time virtually all patients are taking oral liquids, and the venous and urethral catheters have been removed.

Wound.—The burn wound is cleansed of foreign material and all blisters and nonviable tissue

are debrided at once. Occlusive dressings are applied with clean but not sterile technic and thoroughly soaked with dilute aqueous silver nitrate. Eight to 12 thicknesses of coarse mesh gauze are placed upon the wound and held in place with Kerlix rolls, with particular care not to constrict the body part. The patient is covered with one to two dry, light cotton blankets and transferred to an electric circle bed if the dorsal body surface has been burned. The dressings are kept moist with warm silver nitrate solution and the covering blankets changed often enough to remain dry. For burns exceeding 20 per cent body surface area, air conditioning is prohibited.

The burn wound is dressed and aggressively debrided daily; pain and/or bleeding are end points indicating viable tissue. Narcotics and barbiturates are avoided when possible. As soon as dull, flat granulations appear, grafting with infiltration anesthesia for the donor site is performed two or three times weekly. General anesthesia is necessary upon occasion. Postage stamp grafts are employed exclusively and dressing and debridement are continued daily.

Supplementation.—All patients receive appropriate tetanus immunization. High calorie diets, oral iron preparations and vitamins are used routinely. Digitalis compounds are administered to elderly patients sustaining large burns or if evidence of congestive heart failure or other cardiopathy is noted. Because profound hyponatremia and hypokalemia may result from the application of hypotonic silver nitrate solution on the porous burn wound, the following are administered depending upon the size of the patient and of the burned area:

- (1) Enteric-coated sodium chloride, 4-24 Gm. daily
- (2) Potassium gluconate elixir, 5-40 ml. daily
- (3) Calcium lactate, 1.2-9.6 Gm. daily

Clinical regulation is usually easily established and maintained with twice weekly blood studies. More frequent analyses with urine sodium and potassium determinations are often necessary in the first week until the requisite oral dosages are established.

Antibiotic therapy is reserved for specific complications: approximately one third of our patients do not receive antibiotics in any form at any time.

Rehabilitation.—Active use of all injured parts is encouraged from the start. Grafting technics not requiring immobilization facilitate this aim. Hydrotherapy is begun as coverage nears completion.

Results

The five most badly burned survivors as well as an additional less badly burned patient were treated as described. Brief case summaries follow:

Case 1.—A 61 year old man incurred deep burns over 30 per cent his body while attempting to rescue his wife from the burning vessel. The neck, shoulders, and both upper extremities were deeply burned, but the thorax and face were less badly injured. Treatment of shock with intravenous Hartmann's solution was begun about eight hours post-injury and occlusive dressings saturated with 0.5 per cent silver nitrate solution were applied to the burns. He was flown to Miami on the second post-burn day. He was alert and his vital signs and urinary excretion were satisfactory. Oral intake, including sodium chloride, potassium and calcium supplements, was begun and the intravenous infusion discontinued. Standard wound care was instituted.

On the fifth post-burn day, asymptomatic atrial fibrillation developed. Rapid oral digitalization produced reversion to normal sinus rhythm. He continued to take digoxin daily until discharge. By the sixth day after burning, the eschar upon both forearms was necrotic, blue-green, and smelled sweet. The patient became febrile and wound cultures showed *Pseudomonas aeruginosa* in heavy growth. Necrotic infected areas were vigorously debrided with prompt control of local and systemic sepsis.

By the end of the second week, the back and shoulders were healing well, but the arms and hands were covered with hypertrophic erythematous granulations which grew out nonhemolytic *Streptococci* on culture. Oral penicillin caused immediate improvement in the granulation tissue and the first grafting was performed at bedside on the twentieth day. During the next four weeks, multiple split thickness skin grafts were performed to cover areas of full thickness injury while less deeply burned areas rapidly epithelialized from residual dermal elements. By the eighth week, all wounds were completely covered. The patient was discharged on the fifty-eighth post-burn day having lost six pounds during confinement.

Case 2.—A 57 year old man sustained burns over 78 per cent of his body while escaping the sinking ship. Second and third degree burns covered his face, neck, upper extremities, entire trunk, and dorsum of both legs. He arrived in Nassau some eight hours later, alert and oriented, but requiring narcotics repeatedly to relieve his discomfort. To maintain an adequate urinary output during the first 24 hours of hospitalization, 11,500 ml. of intravenous fluids was needed. Although he was badly burned about the face, respiratory difficulty was conspicuously absent. Routine burn wound care was begun and he was flown to Miami on the afternoon of the second post-burn day when he appeared anxious but fully resuscitated.

Oral alimentation with standard supplements was begun on the third day following injury. Despite high humidity oxygenation, moist basilar rales developed and he began to cough up blackened tenacious sputum. He remained afebrile and his respiratory symptoms cleared coincident with tetracycline therapy. Mild hyponatremia was corrected by the infusion of 250 ml. 3 per cent salt

solution on the sixth post-burn day. The following day he became febrile and continued poorly cooperative. Leukocytosis and moist rales were noted, but dyspnea and tachypnea were absent. On the evening of the eighth day, the patient vomited and died shortly thereafter.

The burn wound was uninfected at postmortem examination. A freshly perforated duodenal ulcer had been effectively sealed by the gallbladder. Bilateral pneumonia, complicated by advanced emphysema and aspiration, was also noted.

Case 3.—The wife of the patient in case 2, 56 years of age and burned over 48 per cent of her body surface area, experienced a most uncomplicated convalescence. Burn shock was treated with 6,500 ml. of electrolyte solution and she ingested another liter during the first day of hospitalization. She always appeared well following transfer on the second day. Her burns, confined to the dorsal body surface, proved to be deep partial thickness injury and healed without grafting. Slow recovery of extremity function was aided by hydrotherapy, and she was discharged on the fiftieth post-burn day.

Case 4.—A 65 year old obese retired seaman with known hypertension and bronchial asthma was burned over the upper half of his body. Initial treatment with intravenous lactated Ringer's solution and 0.5 per cent silver nitrate saturated dressings was begun in Nassau and he appeared fully resuscitated when transferred to Miami on the second post-burn day. He remained well until two days later when productive cough, bilateral expiratory wheezes and fever were noted. High humidity oxygenation was supplemented by systemic tetracycline and positive pressure respiratory therapy. Clinical improvement was noted immediately and standard oral intake and electrolyte supplements were begun. Cellulitis about a saphenous cut-down site developed on the seventh post-burn day but responded to local care with dilute aqueous silver nitrate and systemic antibiotics.

On the twelfth post-burn day, dyspnea, tachypnea, tachycardia and moist basilar rales were noted. He was afebrile and thought to be in congestive heart failure. Clinical response to digitalis compounds was prompt. Rapid wound healing from deep dermal elements and the periphery of the burn ensued. Skin grafts were unnecessary. He remained well thereafter and was discharged on the forty-third post-burn day. He lost 10 pounds during the illness and all wounds were covered by the fifty-eighth post-burn day.

Case 5.—A 23 year old woman incurred a massive deep burn of 88 percent body surface attempting to save her mother from the sinking ship. At some time following rescue she received two or three injections of metaraminol, 10 mg. During the first 48 hours post-burn, she required 20,650 ml. to maintain adequate urine secretion, an amount almost half again as much as is usually required per square centimeter of burn. It is interesting to speculate that the vasoconstrictor agent which is known to reduce renal blood flow may be responsible for the increased requirement for lactated Ringer's solution when urinary output was the sole criterion of infusion rate. She was responsive, but soporific when transferred to Miami on the day after injury. Although urinary excretion was satisfactory, respirations were 30 min., pulse 140/min., and temperature 100 F. Laboratory studies showed hypokalemia and hemoglobinuria, the latter probably representative of the depth and size of the injury. Her face was badly burned and edematous, and she expectorated tenacious, blood-tinged, yellow-grey sputum with difficulty. These signs and symptoms improved with high humidity oxygenation, assisted respiration, and frequent nasotracheal suction. By the fourth post-burn day she was thought to have pneumonitis and tetracycline therapy was begun. The pulmonary problems persisted, but diuresis proceeded uneventfully.

About 30 per cent of her body surface area was cadaveric and aggressive debridement began. Thoracic roentgenograms showed a persistent pneumonia and therapy was altered to erythromycin and chloramphenicol. Diarrhea developed in the second post-burn week and she vomited and became lethargic on the thirteenth day after burning. Abdominal examination was normal. Lethargy and a serum sodium concentration of 123 mEq./L. were both corrected by infusion of 200 ml. 3 per cent salt solution. Subsequent thoracic roentgenograms showed improvement; however, the wounds deteriorated and debridement with renewed vigor was undertaken. Blood cultures were repeatedly negative, but she was considered to have classic *Pseudomonas* burn wound sepsis and colistin therapy was instituted. She became anemic and was given a blood transfusion, generally appearing progressively more ill. Hypotension and unresponsiveness were indications of possible adrenal exhaustion and large doses of steroids were administered. Acute gastric dilation occurred and was treated by nasogastric drainage. Her condition deteriorated systemically, and locally upon the wound were florid *Pseudomonas aeruginosa*. On the twenty-third day, she appeared more alert with a peculiar sense of well-being. She was hypothermic and died suddenly later that day.

Autopsy demonstrated pneumonia, multiple superficial gastric ulcers, and multiple hepatic abscesses due to *Pseudomonas*.

Case 6.—A 61 year old man was transferred to our service on the fourth post-burn day for treatment of burns of the hands, face, neck and shoulders of less than 10 per cent body surface areas. The head and trunk healed rapidly. Burns of the dorsum of the hands, initially thought to be full thickness injury, also reepithelialized with such rapidity that he was discharged with virtually normal hand function 13 days after admission.

Discussion

The patients in the cases reported demonstrate the advantages, as well as the disadvantages, associated with the treatment of burn shock with lactated Ringer's solution and of the wound with dilute aqueous silver nitrate.

Control of infection in four of five large, deep burns was impressive. Aggressive debridement of all nonviable tissue is requisite for success and must be pursued daily. The young woman in case 5 illustrates the limitations of the method, emphasizing that at best it only complements established principles of wound care. Reepithelialization of deep dermal burns in the patients in cases 3 and 4 occurred without grafting between the twenty-fifth and fifty-eighth post-burn day. The burns sustained by the patient in case 1 healed satisfactorily by a combination of "postage stamp" grafts and regeneration of epithelium from residual dermal elements about hair follicles. The management of his burned hands, as well as those of the patient in case 6, in this manner is a distinct departure from accepted methods. The func-

tional result of reepithelialization and grafting over tendons with thin skin has been highly acceptable.

The efficacy of Hartmann's solution in the correction of burn shock is all the more notable because in these patients, four of whom exceeded 50 years of age, effective treatment was not instituted until eight or so hours after burning. The absence of renal complications and/or congestive heart failure in this high risk group seems most significant and has been confirmed in the 40 some patients we have treated for burn shock to date.

The treatment of respiratory injury by high humidity oxygenation, assisted respiration, and endotracheal suction has largely replaced tracheostomy in our practice. Not only are these techniques effective—witness that four of these patients actually expectorated grey-black mucus for 48 hours or more—but the unprotected trachea is not as readily subject to infection from the wound as when tracheostomy has been performed.

Death of the patient in case 2 emphasizes the threat of systemic disease upon an otherwise satisfactorily progressing burn illness. The pneumonia was clearly aggravated by lack of cooperation with respiratory therapy and advanced pulmonary emphysema. The terminal emesis was the first sign of alimentary dysfunction. Because of his anxiety and other personality characteristics, he was thought to bear a significant risk of Curling's ulceration. Our experience, now confirmed by others, suggests that medicinal therapy is of little prophylactic or therapeutic value. Early operation is recommended at the first complication arising from burn stress ulceration.

The favorable effect upon burn mortality apparent in this report prevails in our entire experience which exceeds 70 patients at present.

Summary

The survivors of the S.S. Yarmouth Castle provided an illustrative assessment of the advantages and disadvantages of some new methods in burn care. These are discussed in detail and the rationale of therapy outlined.

References are available from the authors upon request.

► Dr. Polk, Jackson Memorial Hospital, Miami 33136.

Magnesium Deficiency in Ulcerative Colitis

MIHALJ MATKO, M.D.

A lowered magnesium concentration occurs in various disease states. A case is reported in which the syndrome of magnesium deficiency was associated with ulcerative colitis.

Report of Case

A 32 year old white married woman was admitted to another hospital in March 1964, following onset of abdominal pain, bloody diarrhea, fever and anemia. After a diagnosis of ulcerative colitis was established, she improved and was discharged following treatment with Depo-Medrol, enemas, blood replacement and diet.

In May 1965, she had an exacerbation associated with marked weakness and was admitted to Orange Memorial Hospital. On physical examination, the temperature was 102.8 F., pulse rate 100 per minute, respiration 20, and blood pressure 110/70 mm. Hg. Icterus, generalized abdominal tenderness, enlargement of the liver and marked pallor were present. The hematocrit value was 15, the white blood cell count 5,400, serum bilirubin 3.2 mg. and potassium 3.5 mEq.

She received whole blood transfusions, intravenous ACTH drip, Terramycin and potassium supplements, but after initial improvement severe anemia and clinical and electrocardiographic evidence of potassium depletion developed. After vigorous blood and potassium replacement, a proctocolectomy with permanent ileostomy was performed on July 13, 1965.

The postoperative period was complicated by wound dehiscence and a need to continue intravenous feeding because of gastric suction. Fifteen days postoperatively, she became delirious, disoriented, hallucinatory and aggressive and manifested tremor and twitching. The electrocardiogram showed ST-T abnormality. Reflexes were hyperactive (table 1).

Four grams of magnesium sulfate was given intravenously in 250 ml. of 5% dextrose in water over a two hour period. Shortly after she received the magnesium sulfate, the sensorium cleared and evidence of neuromuscular irritability subsided. She received additional magnesium sulfate over the next four days.

After a prolonged convalescence she was discharged on September 16.

Discussion

The adult body contains 21 to 28 Gm. of magnesium or about 43 mg. per kilogram of fat-free tissue. About half of the total is present in bone. The ash containing 0.5 to 0.7% magnesium

is similar to potassium in its distribution being relatively concentrated in the intracellular space. The liver and striated muscles have the highest concentration of about 20 me₂. The brain and kidney contain about 17 and 13 me₂ and the red cells concentration contains about 6 me₂. Magnesium is a major intracellular cation. Though its precise mode of action is not known, the majority of the reactions involving adenosine triphosphate are activated by magnesium ion. In their absence activity is either much reduced or absent. The individual systems in which the magnesium as metal participates are too numerous to be detailed here. This ion usually participates in group transfer reactions. The transfer of phosphate, pyrophosphate, sulfate, methyl, formyl, acetyl, alkyl and glycol aldehyde groups utilize magnesium for activation. Thus it is involved in virtually all important metabolic processes such as oxidative phosphorylation of protein, fat, carbohydrate and nucleic acid.

The Cause of Magnesium Deficiency: Malnutrition has been a factor in all patients afflicted, and reduced dietary intake of the element occurs in most of them. In each instance that the syndrome has been observed it was brought about or intensified by some factor which either prevented the absorption or increased the excretion of magnesium.

A. Conditioned Deficiency

1. Failure to absorb a metabolite, inability to synthesize it into biologically active intermediate, and excessive excretion are the simplest examples of conditioning factors.

- a. Severe debilitating disease.
- b. Prolonged acute infections.
- c. Severe alcoholism accompanied by malnutrition.

Table 1

Date	NA me ₂	CL me ₂	K me ₂	Mg mg%	CA mg%	Total protein
7-13-65	140	105	4.2		7.7	
7-14-65	146	108	4.6			4.5 Gm.
7-15-65	141	102	3.3		8.3	
7-28-65	148	105	4.	1.4	9.2	4.7 Gm.
7-30-65			3.9	1.7	7.3	
8- 3-65	140	104	4.7	1.8	9.3	5.9 Gm.
8- 9-65				1.8		
8-18-65				1.8	8.8	
8-24-65				2.1		
8-31-65				2.4		
9- 7-65				1.9	9.2	
9-16-65	139	104	4.3	2.0	8.9	7.3 Gm.

d. Prolonged intestinal malabsorption, or drainage of gastrointestinal contents.

e. Continued parenteral treatment with magnesium-free fluids provides the setting in which this syndrome may be observed. Conclusive proof that the syndrome of magnesium deficiency is due to an alteration of magnesium metabolism is afforded by the correlation of symptoms and signs with chemical changes in the serum. Hypomagnesemia may accompany other conditions. A lowered magnesium concentration has been observed in idiopathic epilepsy, cirrhosis, congestive heart failure, chronic nephritis, eclampsia, diabetic acidosis, pancreatitis, hyperparathyroidism and hyperaldosteroidism. At present it is clinically important to recognize the possibility of magnesium deficiency as a causative factor in disturbance of neuromuscular and central nervous system activity particularly in a patient with malnutrition due to any cause. Sudden onset of delirium, hallucinations, delusions, and wild combative behavior, was seen in our patient.

Clinical and experimental work on magnesium and its relation to the cardiovascular system has been reported.^{1,2}

2. Studies in man have shown that as age increases so does the content of calcium and magnesium in the human aorta. Studies on a limited number of patients with uncomplicated hypertension have shown that the serum magnesium levels were significantly lower and serum sodium levels were higher than were those of the controls. It was suggested that this finding might reflect increased adrenal cortical activity similar to that

noted in aldosteronism in which a low level of magnesium is seen. Magnesium depletion induced by various diuretics has been reported by Smith and his co-workers.³

3. The authors stress the inherent danger of magnesium want in edematous patients receiving long term therapy with certain diuretic agents, and they also point out that an even greater risk of magnesium depletion accompanies various diuretics therapy in alcoholic patients whose supplies of magnesium are often already deficient.

Magnesium depletion was reported in post-surgical patients by Gerst and his associates.⁴

4. Where magnesium deficiency was found in one patient 108 days after the patient was a victim of abdominal trauma and underwent partial gastrectomy, in a second case the patient had repeated intestinal perforation due to regional enteritis.

Summary

A 32 year old white woman presented with ulcerative colitis of approximately two years duration. The physical signs, symptoms and findings on chemical examination of serum were compatible with magnesium deficiency. Remarkable improvement with treatment of magnesium sulfate was obtained in a short period of time. Additional treatment, high protein diet and multiple vitamins with minerals resulted in an uneventful recovery.

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► Dr. Matko, Orange Memorial Hospital, Orlando 32802.

Experience with Phenformin in an Indigent Diabetic Clinic

ROBERT C. PALMER JR., M.D., AMOS L. PREVATT, M.D. and BARKLEY BEIDLEMAN, M.D.

The development of effective oral agents for the treatment of diabetes mellitus has simplified the management of the patient with the disease. Three of the sulfonylureas of varying time action are on the market. This paper is an analysis of the experience with phenformin (DBI) in the Escambia County Diabetic Clinic over a six year period, 1958 through 1964.

Procedure

Phenformin was given a therapeutic trial in 62 patients attending the Escambia County Diabetic Clinic. The response of six was not tabulated because of inadequate information. The 56 remaining patients constitute the basis for this reported experience.

Most patients were seen at monthly intervals and were evaluated clinically by symptoms, indicated physical examination, and weight measurements, and in the laboratory by blood and urine sugar determinations. The fasting blood sugar was determined in an auto-analyzer (ferricyanide method). Occasionally patients were seen oftener than once a month and a few stable patients were seen at less frequent intervals.

The population group of this clinic is by definition indigent and, though efforts were made to encourage adherence to standard ADA diets, it is generally recognized that adherence to these diets in most cases is doubtful.

The DBI used initially was in the form of 25 mg. tablets; while this study was under way the DBI-TD 50 mg. preparation became available and it was also utilized.⁶ No attempt has been made to compare the relative efficacy of these two drugs. The dosage range was 25 mg. a day (one tablet)

to 200 mg. a day (four DBI-TD 50 mg. capsules).

In general the therapeutic approach was to start with a low dose and increase the amount as indicated to the point of control or of intolerance. The duration of treatment with this drug is not included in this report as the reasons for stopping

See editorial comment page 1078

the drug were variable and, in many cases, were not because of drug failure. The prevailing philosophy of the clinic has been to treat with oral drugs whenever possible; thus the patients who received insulin either with or without additional diabetic drugs represent patients unable to be controlled without this drug.

Results

Classification of response was based on the level of most fasting blood sugars recorded while in the study and was interpreted as follows:

Table 1

Response	Fasting Blood Sugar (mg.%)
Excellent	120 or less
Good	121 to 150
Fair	151 to 200
Failure	Over 200

The degree of control of the 56 patients is shown in table 2.

Table 2

Table Control with DBI	Number of Patients
Excellent	12
Good	15
Fair	7
Failure	22

Thus, 34 or 60% of the 56 patients studied attained some degree of control with DBI. Of these 34, 19 were as well controlled on other oral treatments with one of the sulfonylureas, but four were not controlled on any other oral treatment except DBI. Eight patients were controlled on

DBI plus insulin and of these eight, three subsequently were controlled on insulin alone, whereas the other five had the control modified in a favorable direction.

Table 3

Controlled with	Number of Patients
Sulfonylurea or DBI	19
DBI or diet	3
DBI only	4
DBI plus insulin	8
Total	34

Of the 22 DBI failures, five were controlled with another oral agent, nine were not controlled with any oral agent, two were not controlled to any degree of satisfaction by any treatment during the period of observation, and 15 were controlled only with insulin.

Table 4

DBI Failures	Number of Patients
Controlled with sulfonylurea	5
Controlled with insulin	15
Not controlled	2
Total	22

The age range of the 34 patients attaining some degree of control with DBI was from 43 to 86 years. The sex distribution of 29 women and five men essentially reflects the clinic population. Twelve of the 34 patients controlled were considered overweight and 24 were considered to be within 10 to 15% of their ideal body weight. No consistent change in weight attributable to the phenformin itself was observed.

Discussion

The metabolic disturbance in diabetes is complex, incompletely understood, and almost certainly not uniform from patient to patient. Nevertheless, the simple criteria of clinical well-being, maintenance of nutrition, and control of glycemia and glycosuria remain the universally accepted goals of practical management.

Simplicity of effective therapeutic programs aids greatly in avoiding the situation where the disease controls the patient. Frequently when diet control is optimum, and nearly always when it is not, drug therapy is employed to the patient's advantage. Insulin remains the stand-by drug and the one correctly turned to for the young and/or ketosis-prone patient.

The sulfonylureas are effective in many ketosis-resistant cases. They are thought to have as their mode of action the stimulation of pancreatic

islet cells and thus depend on an intact pancreas for effectiveness. Considerable experience was accumulated with two drugs of this class, tolbutamide and chlorpropamide, and recently a third drug with intermediate action, acetohexamide, has been added to the therapeutic spectrum.³

Phenformin is a member of a different class of drugs known as biguanides. Though its full mode of action and the underlying stimuli to its action are not known, it does increase muscle glucose utilization, thus augmenting the action of insulin, whether endogenous or exogenous.^{7,8}

Phenformin has been described as the oral hypoglycemic agent with the greatest range of effectiveness.⁵ This study would tend to support this appraisal as manifest by its effectiveness in controlling 60% (34 to 56) of an indigent group of diabetics. This group included patients who had failed to respond to other oral agents, patients who had previously been controlled and then failed on other oral agents, and patients requiring insulin in addition to the phenformin. In addition, it has been shown,^{1,2} and here confirmed, that it has a smoothing out effect in some patients who clearly require insulin for control.⁴ The objection to the use of phenformin on the basis of a high incidence of unpleasant side effects seems to have been largely obviated by the development of the timed disintegration capsule. Drug tolerance in this series was excellent. Only 22% (five of 22) of patients who showed no control with this agent subsequently were adequately controlled with other oral agents. This experience would suggest that the full utilization of phenformin has not been explored and it should be put high on the priority list of drugs to be considered in the management of diabetes.

Summary

Thirty-four of 56 patients studied over a six year period in an indigent diabetic clinic achieved some degree of control with phenformin. It is a safe, well tolerated and effective method of treatment of diabetes.

References are available from the authors upon request.

We wish to acknowledge the assistance of Henry Yonge, M.D. and Charles Kalin, M.D. in the management of these patients. We are indebted to Mrs. Bess Gauthier, R.N., for her helpfulness in the management of the Escambia County Diabetic Clinic.

Supplies of DBI and DBI-TD were generously made available to the clinic as a public service by the U.S. Vitamin & Pharmaceutical Corporation, New York, N. Y.

►Dr. Palmer, 1750 North Palafox Street, Pensacola 32501.



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
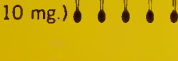
Versatility—The therapeutic efficiency, safety and convenience of Lomotil may be used to advantage alone or adjunctively in diarrhea associated with:


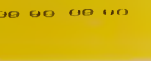
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Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are:

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2-5 yr. . . 1 tsp. t.i.d. (6 mg.) 
5-8 yr. . . 1 tsp. q.i.d. (8 mg.) 
8-12 yr. . 1 tsp. 5 times daily (10 mg.) 

Adults: 2 tsp. 5 times daily (20 mg.) 
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WARNING: Use only after careful evaluation in patients with liver or renal damage, urinary obstruction, or blood dyscrasias. Deaths have been reported from hypersensitivity reactions with administration of sulfonamides. In intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed periodically. Sulfonamide therapy may potentiate the hypoglycemic action of sulfonylureas. **PRECAUTIONS:** Use with caution in patients with histories of significant allergy or asthma. Assure an adequate fluid intake. Because the antihistamines may cause drowsiness of varying degree, warn patients about activities requiring alertness such as driving a car or operating dangerous machinery. Use with caution in the presence of hypertension, hyperthyroidism, cardiovascular disease and diabetes. **ADVERSE REACTIONS:** As in all sulfonamide therapy, the following reactions may occur: headache, nausea, vomiting, diarrhea, icterus, hepatitis, pancreatitis, urticaria, rash, fever, cyanosis, hematuria, crystalluria, proteinuria, blood dyscrasias, petechiae, purpura, neuropathy and injection of the conjunctiva and sclera. If

one or more of these reactions occur, the drug should be discontinued. With antihistaminic therapy there have been reports of sedation varying from mild drowsiness to deep sleep, dizziness, lassitude, inability to concentrate, fatigue, incoordination, tinnitus, blurred vision, diplopia, euphoria, nervousness, insomnia, tremors, palpitation, hypotension, headache, chest tightness, urinary frequency, dysuria, tingling of the hands, dryness of the mouth, throat, and nose, gastrointestinal disturbances such as epigastric distress, anorexia, nausea, vomiting, constipation and diarrhea and very rarely, leukopenia and agranulocytosis. Adverse reactions reported with the use of sympathomimetic amines include anxiety, tension, restlessness, nervousness, tremor, weakness, insomnia, headache, palpitation, tachycardia, angina, elevation of blood pressure, sweating, mydriasis, anorexia, nausea, vomiting, dizziness, constipation, and dysuria due to vesicle sphincter spasm. **PACKAGE INFORMATION:** Trisulfaminic Tablets: Supplied in bottles of 100 tablets. **CAUTION:** Federal law prohibits dispensing without prescription.

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President's Page



Fees

By action of the House of Delegates in May 1966, the Florida Medical Association will recognize no fee schedules except those of Blue Shield and will henceforth expect reimbursement of its members on the basis of usual and customary fees prevailing in their area (Resolution No. 66-4). The principle involved is fine because PL 89-97 set the pattern by stating that payment for physicians' services would be based on "reasonable" charges and bear no relationship to the income of the patient. Unfortunately, principles can seem great at the time, but the practical results can create a dilemma and an impasse between the providers of medical care and those governmental agencies which have assumed the responsibility of paying for physicians' services directly or reimbursing the patient therefor.

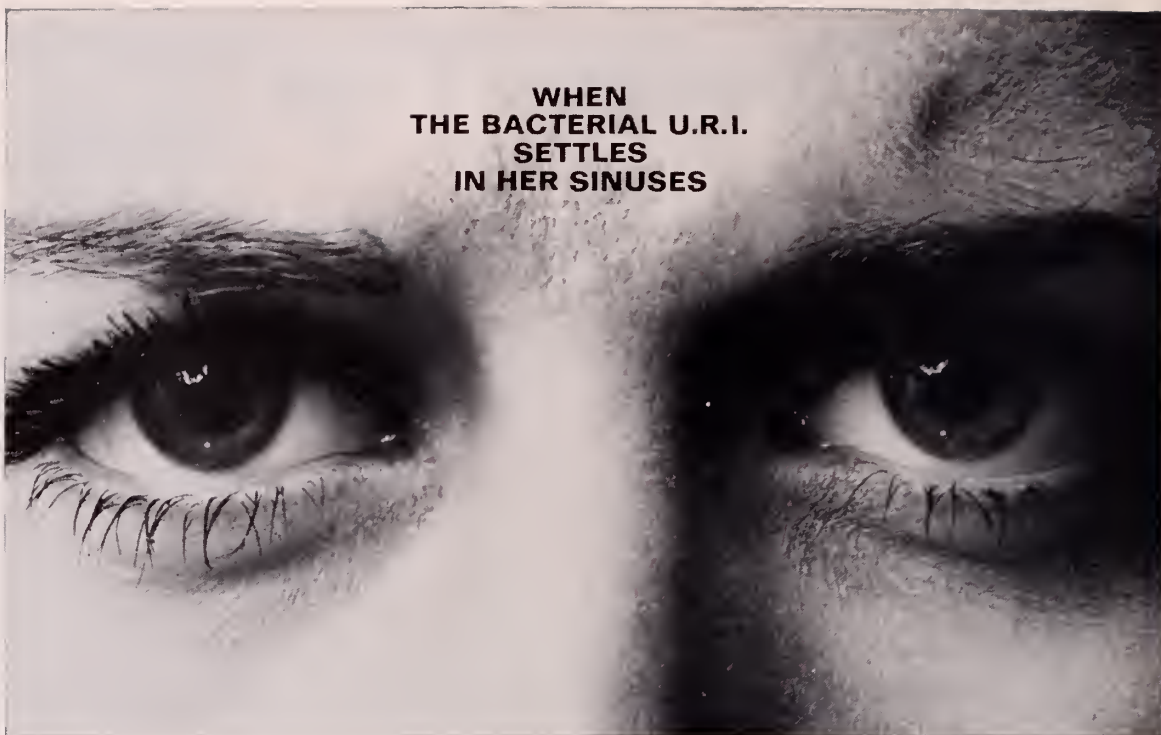
The present misunderstanding between physicians and the Industrial Commission over Workmen's Compensation fees is a case in point. Present policy of Workmen's Compensation in payment of medical fees is to use the 1962 FMA Relative Value Studies with a conversion factor of 4.5 for medicine and surgery and 5.0 for laboratory and x-ray. Earlier in this year, a request was made by FMA to the Industrial Commission to increase the conversion factor to 5.0 across the board by a certain date or FMA would withdraw recognition of the Workmen's Compensation fee schedule. The request was not granted. The net result is that FMA recognizes no Workmen's Compensation fee schedule as presently printed. Counsel for the Industrial Commission says that a fee schedule is required by law. There is some doubt about this requirement amongst many members of FMA. This point must be cleared up.

Recently, some of the specialty societies have communicated with the Industrial Commission, requesting that Workmen's Compensation fee schedules be negotiated by specialty. The chairman of the Industrial Commission refused to grant this request and said that FMA was still recognized by the Commission as the official spokesman for the physicians of Florida. He also stated that he believed only chaos would result if negotiations were attempted by specialties. I agree with this opinion. FMA *must* be the spokesman for the physicians of Florida. I have previously stressed the importance of remaining united. Anything less would fragment, undermine and destroy the effectiveness of our Association.

Here is the dilemma. We now have as FMA policy recognition of no fee schedule and compensation for medical services on the basis of usual and customary fees. How shall we negotiate? What is the best method of solving this stalemate? I believe that official representatives of FMA, industry and Workmen's Compensation must get together, reach an understanding and come up with something fair and reasonable for those who provide medical services and those who pay for these services. Can agreement be reached *without* a fee schedule, or *without* a Relative Value Schedule or *without* a conversion factor? I don't know. My job is to carry out FMA policy. We must do something soon. I would welcome any answers to this problem and any suggestions. It is very important to the physicians of our state and to the future pattern of medical economics in Florida.

George S. Palmer

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Precautions—Some individuals may experience drowsiness, ano-

rexia, and slight gastric distress. If excessive drowsiness occurs, it may be necessary to increase the interval between doses. Persons on full dosage should not operate any vehicle. Use may result in overgrowth of nonsusceptible organisms. If infections appear during therapy, appropriate measures should be taken. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Infections caused by beta-hemolytic streptococci should be treated for at least 10 full days to help prevent rheumatic fever or acute glomerulonephritis. Use of tetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect has been observed in usual short treatment courses.

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Physician Representation On Hospital Governing Boards

In 1963, the following resolution was passed by the House of Delegates of the Florida Medical Association:

Resolution 63-14

Hospital Boards

Board Of Governors

Whereas doctors, as citizens, should take an active interest in community affairs, and

Whereas hospitals need active support and advice of the members of the medical community and only by having physicians active on governing boards can proper liaison between administration and staff be maintained, and

Whereas Doctors of Medicine possess knowledge that can be valuable to hospital administration; therefore be it

RESOLVED, That the House of Delegates recommend to each county medical society that it actively and aggressively promote membership by members of their respective societies on governing boards of the hospitals within their area, and be it further

RESOLVED, That the House of Delegates recommend to the Governor of Florida that members of the Florida Medical Association be represented on the advisory boards of state hospitals, and that copies of this resolution be forwarded to the Governor of the State of Florida, the Florida Senate and the House of Representatives.

Yet today, new hospitals within our state are adopting bylaws stipulating that there be no physician on the hospital board. The model bylaws prepared by the American Hospital Association include such a statement and are used as a guide by most originating groups. The need to include this exclusion is stressed by many hospital administrators as an essential statement within the governing rules for board membership selection.

This situation has come about for many reasons. The physician has in the past declined to accept this responsibility, or, accepting, has not been a working member of the board. Physicians,

being busy, frequently sidestep civic responsibilities with a "too busy" explanation. This statement repeated frequently has convinced community leaders that there is no need to ask the doctor, thinking he is not available. The development of the able professional hospital administrator has created a new authority on all hospital matters—one always available and willing to work for the board, as this is his job. The American Hospital Association recognized the need for an administrative authority and, utilizing these men, has developed a strong organization which influences all areas of hospital operation; at times even the doctor-patient relationship. Many administrators and the American Hospital Association believe that all professional matters must come to the hospital board through a joint committee of selected physicians and selected board members. The opinions of this joint committee are discussed at board meetings with the administrator present to present his views, whereas the physician has no opportunity, unless invited, to give the reasons influencing his judgment.

These facts have allowed, even encouraged, the physician to "let George do it."

With increasing governmental intrusion into all big business—and hospital management is big business—there is an increasing intrusion of the hospital into the patient-doctor relationship. The hospital is, partly from choice and partly from necessity, becoming the central unit available for controlled inpatient and outpatient care. Governmental agencies give suggestions and offer aid for all aspects of patient care. These suggestions and this aid, carrying with them governmental con-

trol, are usually best suited to hospital management. The ideas are usually popular with the management for they create a bigger business to manage; and in turn, few board members can resist the usual something-for-nothing governmental approach. As a result, the hospital is becoming the means for furnishing to the community all medical care and many predict the doctor-patient relationship in time will be the hospital-employed doctor-patient relationship.

To say that all new ideas are wrong, or that change in the practice of medicine is not needed, is foolish. It is also foolish for physicians to allow changes influencing the practice of medicine to be made by any board upon which they have no official voice.

The hospital administrator is not against the doctor; the American Hospital Association is not against the doctor; yet each is for what will give the hospital the largest, most efficient capacity for work, influence in the community and black ink on the balance sheet. In such an effort, the patient is sometimes forgotten and the doctor's voice as to what is best for the patient is sometimes not heard.

The hospital is to be the center of medical care. If this is to be, we must guide such care to provide the best possible patient care. To me, this care is best given in a knowledgeable, direct and personal doctor-patient relationship. To preserve this relationship, it is necessary that physicians serve on hospital boards, ideally for a continuous long period of time. Knowing that this raises problems, it seems reasonable that each hospital board composed of over five members have two physicians on the board; that these physicians be elected to serve for two year terms, one being elected each year; that these men might ideally be the president and president-elect of the hospital staff—men selected by the active staff for their leadership and expected by the administration to carry the load of professional and patient care responsibility.

The physician in his community, at the state level and through his national organizations, must accept this responsibility, must work for a voice on the hospital board and must use his voice for the best interest of the patient.

Resolutions, though adopted, accomplish nothing.

T.M.

County Indigent Care—Benefits Derived From an Intern Training Program

It is not often that a small county hospital of 158 beds such as the Polk County Hospital can participate in postgraduate medical education. The primary factor bringing this program to a reality was a desire on the part of the practicing physicians in Polk County to have a training program associated with the expanding Lakeland General Hospital, Lakeland. Interested and farsighted physicians on the Lakeland Hospital staff initiated the groundwork for such a program just prior to an expansion of that hospital in 1958. A postgraduate medical education committee was appointed and appropriate steps taken to inform the hospital's governing board and the board of county commissioners of the desirability of such a program and its benefits to both indigent and private patient alike. The board of county commissioners was receptive to such a plan as the county hospital facility under its juris-

diction found it exceedingly difficult to obtain medical personnel for proper medical care.

In June 1960, a fully qualified director of medical education was appointed, his salary to be met on an equal sharing basis by the Lakeland General Hospital and the board of county commissioners.

The preliminary application for approval of intern training was forwarded to the Council on Medical Education and Hospitals of the American Medical Association on Aug. 16, 1960. At the plenary session of the council on Dec. 5, 1960, it was learned that the postgraduate medical education program had been approved with two conditions: (1) that the Polk County Hospital obtain accreditation by the Joint Commission as soon as possible and (2) that an outpatient clinic for indigent patients of Polk County be established at the Lakeland General Hospital.

The board of county commissioners appointed a full time medical director for the county hospital Feb. 1, 1961. Full organization of the medical staff was then initiated. Barely over a year later, in April 1962 the hospital gained full accreditation by the Joint Commission for Accreditation of Hospitals.

The first group of interns made their start July 1, 1962. Five interns began their service between the Lakeland General Hospital and the Polk County Hospital the first year. Eight interns were obtained the second year of the program and 12 interns were matched the third year. As of this year the combined program is approved for 16 interns.

What are the benefits to be derived from a postgraduate medical education training program? We will endeavor to outline some of the direct and indirect benefits of the program as they relate to the establishment of better medical care to the indigent patients of Polk County and, in turn, relative beneficial effects for the taxpayer.

Better Medical Care

The atmosphere of a teaching program is equally stimulating to the young physician and to the preceptor. The frequent holding of teaching exercises such as "teaching grand rounds," clinical pathological conferences, and bedside reviews by chiefs of services and trainees all serve to raise the scientific level of medical perceptiveness of the participants. For example, prior to conducting a teaching exercise, the teacher must review the basic principles of the medical problem concerning him, and must be able to impart them to the young physician. He must be keen enough to cope with the latest knowledge imparted to the recent graduate of the nation's leading medical schools. In turn, the young physician must thoroughly review the problem prior to the exercise in order to avoid failure and ridicule before his peers in conference.

These exercises are frequent enough to serve as a constant stimulating factor in a teaching hospital that is not found in a nonteaching hospital. This added stimulation encourages a keener perceptiveness that directly benefits the patient. Hospital days are reduced through earlier and more scientific work-ups. Knowing that each case will be reviewed by a group of peers results in a more accurate solving of the problem through

more prompt attention to physical diagnosis, augmented by appropriate scientific clinical laboratory evaluations. Earlier diagnosis, therefore, leads to earlier therapy, fewer hospital days and more rapid turnover of hospital beds. The net results are earlier return of the patients to an earning capacity and, in turn, a quicker return to a status of tax-paying citizens and off the welfare rolls.

Another benefit to the young physician is the inculcation of a feeling of compassion and perceptive responses, in addition to the requirement that he be a scientist. He will recognize that the art and skill which he will need to develop and place at public service are the true end of professional endeavor. Furthermore, he will find that the professional man's highest reward is the contribution he can make in the promotion of the patient's welfare through his mastering of the problem confronting him in each patient in the pursuit of further knowledge for its own sake.

The wards of the hospital are the laboratories of the clinical years. The skilled application of medical science to the care of patients is learned during the house officer training period. The young physician must develop several skills progressively and simultaneously. The application of rapidly advancing science to diagnosis and treatment, the understanding of the variables in the natural history of the disease and appreciation of the further variables introduced by the patient as an individual, the obligation to study, the learning of ward and hospital administration and the understanding of professional cooperation with colleagues are all developed during the postgraduate years. The medically indigent patient benefits because he is treated by staff physicians who have achieved higher standards of scientific inquiry into their case. Newer opinions are given based on the latest teachings of leading medical schools.

The greatest contribution the teaching program makes to better medical care of the medically indigent patient is the augmentation of the local resources through the availability of the most highly skilled medical and surgical specialists in Polk County. As a result of the teaching program the great majority of the specialists of Polk County are available for consultation, without compensation, to the medical staff of the Polk County Hospital. These voluntary contributions of Polk County physicians, participating in the

intern program, have resulted in substantial savings in the usual consultant fees that were common practice prior to the establishment of the teaching program.

The necessity for obtaining accreditation of the Polk County medical facilities has been a milestone in upgrading standards of medical care for indigents in Polk County. The fact that this highest recognition by the Joint Commission for Accreditation of Hospitals after a short span of 15 months after the request for evaluation is direct evidence of the many months of hard work and the desire of the staff that the standards of medical care afforded to the medically indigent people of Polk County be equal to the best in the United States. In addition, the approval of the training program by the Council on Medical Education of the American Medical Association is also an indication of the rapid growth to maturity of the medical community of Polk County.

Benefits To The Polk County Hospital

While the program is expensive to maintain, the returns cannot be evaluated on a dollar basis alone. The board of county commissioners has an obligation for the welfare and medical needs of the medically indigent patients that come to the Polk County Hospital. The commissioners cannot, however, escape the fact that they are also equally and morally responsible for the quality of medical care given in the Polk County Hospital. Although hospital costs have gone up during the last 15 years, at the same time it is evident that the hospital stay per patient has been reduced markedly because of earlier diagnosis and more expeditious and effective treatment. We should be thinking not only of the cost for the program but also the cost to the taxpayer, if we did not have the program. Can we afford to have an institution with less than the highest standards of medical care? Can we afford the long hospital days before final diagnosis is made because of lack of adequate personnel? Can we afford to do without the necessary consultations with the best medical specialists and surgeons, who render their services without compensation in most cases? Can we do without the teaching program that makes mandatory a review of each patient's condition and the treatment given?

Certainly, the presence of a well trained house staff provides the strongest possible stimulation

to continued study and advancement on the part of the physician. Few people are more eager to display their new-found knowledge, or more impatient of incompetence in their elders, than the man who has just graduated from school. These men are not "cheap" doctors hired to make the role of a staff physician easier. They are not there to provide low cost and second quality medical care to the indigent patient. They are not there to "beef up" the nursing service or make up for the lack of competent laboratory service.

Advantages Of A Teaching Program To The Medical Staff

The atmosphere of a postgraduate teaching program is one of continual progressive thinking. On the part of the medical staff, the stimulus of preparing lectures, conferences and seminars requires a continual review of basic principles of scientific medicine. It is often said that this effect on the teacher is often greater than on the younger physician. This stimulus results in automatically upgrading the effectiveness of the medical staff and results in better medical care.

The effects of the teaching program overflow to the other services. The nursing service also benefits through newer and higher professional requirements. Better record keeping and frequent reviews of the standards of nursing care result in better medical care of the patient.

The teachers that the young physician meets play an important role in his career. The senior staff man and the attending physician are often emulated by members of the house staff. The young physician learns through observation and discussion of the best methods and techniques in diagnosis and treatment practiced not only by his immediate preceptor but also by other experts and consultants. In the give and take of scientific discussion he learns the value of sharing information and also seeking different approaches.

Summary

It is readily apparent the benefits derived from an intern training program are demonstrable and far reaching. The patient receives better overall medical care. The medical staff is upgraded through its influence. The hospital elevates its many patient care ancillary services by its impact and the county gains a prestige factor which is frequently overlooked.

We find that an intern program and its concomitant benefits far outweigh the monetary outlay required. The image of the Polk County Hospital as an institution of healing has increased tremendously in the eyes of those who benefit

from its services as patients, and also in the eyes of the professional groups in Polk County.

Quentin C. DeHaan, M.D.
Bartow
John Dominick, M.D.
Lakeland

"I Could Not Believe . . ."

This is a true story; only the names and some of the facts have been changed to protect—the publisher.

It seems that somewhere in the United States in the not too distant past there lived (and still lives) a school teacher in a small town. We'll put a black mask across her face and call her Mrs. Smith. Now, this Mrs. Smith had a lovely teen-aged daughter we'll name Janice. Unfortunately, this young girl took sick and was admitted to a hospital by an internist for "acute violent rheumatic fever with heart damage beginning." Mrs. Smith was told "a special nurse would not be necessary and that she would be permitted to stay with the daughter in the room." At seven o'clock, the internist visited the patient and, apparently, was satisfied with her condition. As the evening wore on, however, the girl became progressively worse. Mrs. Smith, an intelligent human being, realized that the child was critically ill and attempted to get a nurse to see the patient. The nurse, however, "ignored her and continued walking down the hall." At one time when she asked for a soft drink for her daughter, Mrs. Smith later testified in court, the head nurse stated, "I have no way of getting a soft drink at this time of the evening for patients. If you want one, go down to the machine and get it." Mrs. Smith further testified that in her attitude, the nurse was "very nasty," "grouchy," and "rude." As the situation rapidly deteriorated, the mother begged the head nurse and two other nurses in the hall to "Please come and check my child."

It seems that Mrs. Smith's pleas were totally and completely ignored. According to testimony, no medical or paramedical person went near the patient. That long evening, as she noticed "blueness" about her daughter's lips and fingernails, Mrs. Smith continued to ask frantically for help

and was denied it by all she contacted. When the eleven o'clock shift came on, according to testimony, Mrs. Smith renewed her pleas to the new charge nurse and was told, "I know all about Janice. All she needs is a night's rest and if you will sit down and be quiet, she will get it."

When the "blueness" increased around her daughter's mouth, Mrs. Smith asked the nurse to call the physician. She was told, according to court testimony, "We can't call a doctor for no reason." Then, when Mrs. Smith suggested that she herself call the doctor, a nurse retorted, "If anyone calls a doctor from this hospital, we call him."

Finally, when Mrs. Smith, in frightened desperation, was prepared "to rush into the street for help," she found her way to the office of the Supervisor of Nurses who took immediate action and notified the doctor. The internist arrived at the hospital, according to testimony, between twelve forty-five and one o'clock in the morning of the fifteenth. He asked, "How did this child get in this condition?" The mother replied, "For four hours the child has been in heart failure and nobody would come to look at her, much less do anything for her."

The internist worked swiftly. Unfortunately, the sands of time were running out for Mrs. Smith's little girl; Janice died at one o'clock on the morning of the sixteenth.

As one who has been in the general practice of medicine for almost a quarter of a century, I have met a few haughty, know-it-all, unbending nurses. I have also run into a few hardened, know-it-all physicians. And, I have encountered physicians and nurses with an "I don't give a damn" attitude. But, in all fairness, I must add that I have also come upon salespeople, mechanics,

barbers, TV repair men, plumbers, carpenters, and others with a similar attitude.

"But," one is certain to object, "the TV repair man, the plumber, the mechanic, the carpenter, the salesman do not deal in our most precious commodity, Life." Very true, but I offer this more in a negative sense than in a positive one to demonstrate what we all know—if we take the time to consider—but do not care to recognize: physicians and nurses are human, too. They, also, are subject to like and dislike, love and hate, to whim and nostrums, to fears and doubts, to desire and indifference, to vanity and modesty, and all the various shades and degrees between.

There are many factors involved in making a nurse act as did the nurses in the vicinity of Janice in October, 1960. There are the minor ones which can influence anyone: an intense menses, an annoying dermatitis—perhaps a nagging gastritis or an aching tooth which should have been extracted days ago. There are the major ones: a serious personality defect or even a misanthropic nature, or—more important and what is worse for us all—a sign of the times. In the past 10 years, one has observed more and more this "sign of the times" which is bound up in phlegmatism, a cold unconcern for one's fellowman, and an acute fear of "becoming involved."

It is a sign of the times that many doctors no longer carry a physician's emblem attached to the license plates or some other parts of their cars, that many doctors no longer make night calls, let alone regular old-fashioned house calls in the working hours of the day, that many physicians no longer respond when a plea goes out, "Is there a doctor in the house?"

It is fitting and natural to inquire, "What has wrought these changes?" There are a multitude of socioeconomic shifts one could not even have imagined a brief century ago, even a short half century ago. For one thing, the heavy taxes paid into the various government agencies cannot be ignored. Everyone, at one time or another, has heard that old saw, "After the first twenty thousand, I'm working for the government." There is much truth in this statement. A few months ago, in the wee hours of the morning, I phoned a surgeon from a patient's home to see what I believed to be a patient with acute appendicitis in need of surgical intervention. He refused to come out then, advising me to send the patient to the hos-

pital and promising to see her "first thing in the morning." Eventually, I contacted a surgeon who was willing to leave his warm bed. He concurred with my opinion and did an immediate appendectomy. A week later I ran into the first surgeon in the Doctors' Lounge and chided him gently for letting me down when I needed him. Drawing a pad from his pocket, he demonstrated step by step how, in his income bracket, he would be making approximately one dollar and eighteen cents an hour by coming out to see a patient at three o'clock in the morning. "For that kind of money," he concluded, "I can enjoy my sleep." As he returned the pad to his pocket, he advised me that an electrician pulls down four and a quarter an hour, his helper at least two. "Don't ask me," he said, "what they get for overtime or for work on a Sunday evening. That is," he added, "if you can find one." He stopped at the door. "By the way, I learned the other morning an expert camera repairman who has been trained in a six week Army course gets something like eight-fifty an hour."

Of course, one may comment that to this surgeon, medicine is not an art, not a calling, but just another job he does and wants to get paid for. He might have easily selected plumbing or electrical work for a living. But, on the other hand, who can blame a man asking just and equal compensation for his labors?

Our society has converted too rapidly from a close-knit rural community to a dissociated but exceptionally complex urban commonwealth. As of 1960, seven of every 10 Americans were city dwellers. The same technology which has produced infinite ribbons of highways, sleek cars whose speedometers will register 120 miles an hour, space-eating jets that will deposit a traveler half way around the globe in much less than a day, is responsible also for sabotaging human interrelationships. The farmer of 1920 who lived 12 miles from his nearest neighbor was closer to that neighbor and knew more about that neighbor than today's apartment dweller who sleeps less than 30 feet from his furthest neighbor. If he learns that, during the night, the apartment next to his had been entered and robbed and the occupant beaten up, he may utter a sympathetic "Gee, that's tough" and let it go at that. If he hears that a woman on the floor below had been raped

in the elevator, he may look up from the evening paper and remind his wife to be more careful when she enters the elevator.

This is the flavor of the day, the color—a dreary gray—of our time. This is symbolic of the widespread spirit of “I don’t care.” No longer are we our “brother’s keeper.”

Our great economy, highly-touted to the rest of the world, is another contributing factor. The Affluent Society is what we are sometimes called. In the 1934 Share-Our-Wealth movement, the goal was a chicken in every pot. Today, the goal is more ambitious: at least two cars in every garage. Color television is rapidly replacing black and white television. More electric dish washers are being sold. The luxury items—tape recorders, hi-fi stereo units, cameras starting in price from \$150, electric tooth brushes, walkie-talkies, even electric pencil sharpeners—are commonplace and are found just as frequently in the rooms of our children as in our own rooms. In 1965, Chrysler Corporation sold a record 1,650,000 new cars; in the same year, General Motors reported its highest earnings ever: a whopping 2.12 billion dollars. Each week, the Dow-Jones industrial average edges toward a new high and, it seems every business no matter what is heading for a new record. There is much more money and credit around than ever before to tempt us into such elaborate luxuries as a week in London or in Tokyo (on the installment plan, of course). The doctor, like his neighbors, is making more money than he ever did. He is riding high, wide, and handsome on the crest of this abundant and ever increasing prosperity. He is becoming less solicitous, less concerned with his fellowman. Oftentimes, he offers his services on a “take it or leave it” basis. If someone leaves it, the doctor shrugs his shoulders and passes on to the next patient.

One orthopedist, two years out of a residency in a mediocre hospital, explained a three month delay in sending me a report on a patient by saying that he was completely overworked, that he could spend very little time with either his family or his favorite hobby and, in a fit of pique, advised me I would be doing him a favor to refer my patients elsewhere. I granted him his wish. Money obviously was coming in too quickly for this individual. Probably, he still hasn’t become accustomed to it, but he IS affluent.

This is not to say that all men count service in terms of dollars and cents, that the only reward man seeks before entering heaven is a fat bank account. Nevertheless, the impression that more and more men are doing so grows stronger with the passage of time.

The fault of acquiring a “hardened” attitude does not lie fully on one side of the line. The layman has contributed his share of the blame. There are a multitude of lay people who, having followed avidly the daily, detailed bulletins on former President Eisenhower’s heart attack as well as the facts of President Johnson’s much-publicized cholecystectomy, fancy themselves as belonging to the paramedical professions. There are those who have read about complex heart surgery or a new medication for diabetes in *Red Book*, the *Reader’s Digest* or the *Ladies Home Journal* and consider themselves a specialist on every aspect of medicine. They plague their physicians with all sorts of inconsequential questions about all kinds of diseases. In many instances, they advise for sick relatives. Oftentimes, they attempt to dictate treatment, for example, the man who enters the office and announces to the doctor that he came for a “penicillin shot” for his cold. Perhaps the nurses who ignored Mrs. Smith might have had experiences with laymen who, each week, follow the daring exploits of Dr. Casey or Dr. Kildare. Perhaps, they were up to here with well meaning advice from lay people and assumed Mrs. Smith was taking on the role of a nurse or a doctor. Perhaps they wanted to say to Mrs. Smith, “You stick to your school teaching and we’ll stick to nursing.”

Occasionally, with a hint of nostalgic longing, we look back to the “good, old days.” Historians, pointing out difficult travel, poor communications, lack of certain medications which today are commonplace, indifferent sanitation, the uncertainties of the times, have declared the “good, old days” to be chimerical and illusory. Today, with our incredible communications, our almost unbelievable transportation, our wonder drugs, our near-miraculous surgery, our transplants which existed in the good old days only in science fiction, our greater longevity, our magnificent triumph over the atom, not to mention the glorious chapters of space exploration which will soon put man on the moon, it is easy to believe the historians.

Yet, if we have gained, we have also lost. It

seems that "back in the good old days" medicine was less a business and more an art, that the old family doctor was more concerned with the health of the patient than with the health of his own pocketbook, that he was more available and readily accessible to his patients. Then, he did not sit behind his big desk protected by a platoon of nurses, secretaries, receptionists, and office managers. People DID care a little bit more then. There was more courtesy among people, more gentility, more manners, more of the fabric from which the well bred were cut. Today, in too many instances, we witness a complete disregard of common human decency, a complete breakdown of concern for "the other guy."

Several months ago, a friend with a heavy portfolio of stocks and bonds tucked safely away in his safe deposit box commented on the present bull market. "Boy, I'd like to see this whole thing

break wide open," he commented to me, "something like the Black Monday of '29."

"Why?" I asked in surprise.

"The only times people are nice to one another is either in a depression or during a war. I'd rather not have a war, so. . . ." He held out his hands. "The next best thing is a good, long depression." Evidently, my friend valued better human relations more than he did money.

Somewhere along the road, some place in recent years, the sons of Aesculapius—among others—have lost the touch. A mother in her deepest sorrow, puzzled and bewildered after a long night's vigil, speaks slowly, "I could not believe that it could happen in a hospital in America."

Yes, Mrs. Smith, it could happen in America.

ARTHUR F. SCHIFF, M.D.
MIAMI

Government in Medicine and Medicine in Government

Without doubt, tremendous forces are at work on the medical profession to control the service under the guise of doing good for humanity. Life, liberty, the pursuit of happiness and good health are now a government-given right intended for all. Perhaps the medical profession has not done as much as it should in "medical tithing," but there is no profession, service or business in any country that does not have some sort of price tag on its service or product. The medical profession leads the list in helping a large segment of its fellow man without a price tag. Without good health little can be accomplished by anyone.

As time goes on and the inflationary spiral continues, the other producers of national wealth raise their price or strike to achieve what they think is their fair share of the dollar. Now, the government has legislated that regardless of need those over 65 years of age shall have medical and hospital care. The medical profession is now maneuvering with the government to preserve that indispensable patient-doctor relationship, fee for service concept, and free choice of physician. Yes, government is in medicine.

In a democracy it is believed that the majority

rules. It is believed that the will of the people is expressed by voting for Utopia for themselves now. Utopia for all time is achieved by pushing the right lever in the voting booth. To get that lever pushed requires molding and influencing people to certain ideas. Campaigning, if you will. This maneuvering is designed to convince the voter that this idea or proposal is for his good, not infrequently ignoring the generations to come. This or that course of action is often offered to the public by presenting half truths, publishing parts out of context or by withholding known information or facts. Both sides of the problem are practically never presented by the press or news media. This is called "freedom of the press" (?); but nary a word is said about the "responsibilities of the press." Another way this society accomplishes its goals is by loading committees with persons favorable to its ideas or with those who are easily persuaded. If these methods are challenged, then the cry is "This is not the way to get things done." Very true, this is not the way to get things done in a democratic way. The obvious result is a railroading of ideas and much is "accomplished." The opposing views and facts

are seldom heard.

As the Utopia is developed, it is apparent that those who are willing to work and are going to pay for this Utopia are fewer than those who do not want to work. The "easy way" is voted for in a "democratic" way and the strong, self-reliant individual becomes the socialistic one by innuendo. Democracy gives way to socialism and ultimately tyranny is developed by the bureaucrats who control the purse strings and media of communication. This is history and the present trend.

The future remains in the few strong remaining fibers of our Constitution—the right of free speech and the right to vote. That vote has been used against the strong and self-reliant and now they must use it to stem socialism. This goal requires study of both sides of all questions and consideration of not what is good for us now, but what is good for us 10 or 100 years from now. As far as the physician is concerned, good responsible care of our patients, a united front, teamwork without loss of individuality, and cooperation without selling the soul can accomplish much. The opinion on every issue in the Congress expressed by an organized medical society of 5,500 such as the FMA would not go unheeded. Of course we will make mistakes, but it is a much greater mistake

to do nothing.

How can we implement the expression of our ideas by an organized medical society? (1) Information on all bills in the Congress should be presented by the legislative committee of the FMA to each society member well before its monthly meeting—information for the issues and information against the issues. (2) Place discussion on the monthly meeting agenda and change the by-laws if necessary to do so. (3) Send the votes from each county society to the FMA office for counting and tabulation. (4) Forward the decision of the FMA to our representatives and senators in Washington and Tallahassee. (5) Report the result of this FMA vote back to the county society so that we may present a united front on the home front. (6) Work on issues and problems in our community at the "grass roots level."

When? The time is now. It is later than you think.

This then will be "Medicine in Government."

CARL E. ANDREWS, M.D.
MAXIMILIAN A. CRISPIN, M.D.
HAROLD A. YOUNT, M.D.
WEST PALM BEACH

Basic Concepts

In September 1965 I was privileged to attend the Atlanta Forum of the National Commission on Community Health Services as a representative of the Florida Medical Association. My experiences at this meeting and subsequent developments typify to me the tragedy of the decline of the American system. At least it typifies the practicing physician's part in this decline. It would be much more appropriate to say the lack of participation of practicing physicians since that in reality is what we are faced with. It underscored my feelings of the past few years that most of our problems have been developed through default on our own part. My effort here is another voice of limited experience from which I hope we can develop certain patterns for future action, hopefully to save our constitutional republic form of government.

The material presented to us at the Atlanta

Forum consisted of several hundred typewritten pages of work done by five specific task forces of the National Commission on Community Health Services. Their work in conjunction with the Community Action Studies Project, which was carried out in specific communities around the country, was combined in task force reports and recommendations. It was the responsibility of the Atlanta Forum to be one of four such forums in this country responding to the task force reports. Each of these forums consisted of 300 people from various health-related organizations, and the Atlanta Forum included only 20 practicing physicians out of the entire 300. To say we were outnumbered would be a gross understatement. In spite of this disparity in numbers, however, we believe that the work done by our just being there and being able to respond as practicing physicians to matters that were related largely to the practice

of medicine at the doctor-patient level was gratifying. Most of the recommendations and the work done by the task forces was done largely by economists, socialists, New Dealers, and other "planners" who seemed to have little grasp of the basic American concept of free enterprise, capitalism, and the supremacy of the individual over the government. Certainly, as in most issues laid by such "planners," there is a problem in many fields of medicine. There have always been problems and there probably always will be. The very definition of a profession reminds us that if we are completely successful there is no longer need for that particular profession. Nevertheless it is frustrating to try to decide who is wrong, or if they are wrong, and what we can do about it.

As I am presented the opportunity to observe the leaders in the Florida Medical Association, I am more impressed all the time with their ability to ferret out the key issues in national and state problems as well as our own physician-patient problems and to apply these key principles in making decisions for action regarding the many varied problems. From these observations I am able to delineate certain elementary theses. At the present time I have two that I have found to stand the test of most any of our problems and I am sure there are others. From a constructive point of view perhaps those who read this editorial may concur and add to this list so that we all may benefit from this thinking, each of us recognizing the primary responsibility is good medical care for the patient.

1. Maintenance of a direct doctor-patient relationship in all matters.

At the present time this problem relates primarily to the economic situation; that is, always having the patient pay the doctor and not allowing a third party to intervene between us. This could also apply to patient care, utilization committees, and various other situations.

2. The development and decisions in all medical planning and legislation should relate primarily to the practicing clinical physician.

This concept is also basic and is related to the tendency of the federal government and others to prefer to deal with institutions or groups such as medical schools. This is not to say that these organizations are not important in producing solutions to medical problems. It is to say firmly that the contributions of these institutions should be in relation to the practicing clinical physician and again the doctor-patient relationship. This concept has also stood the test of many questions applied to it.

In summary, I invite my more learned colleagues about the state of Florida to consider these thoughts, and especially the two basic ones presented here as concepts, and add to them for my use and for the leadership of the Florida Medical Association. I realize how elementary these sound, but I also realize how important it is to maintain concepts in the stormy seas of legislative development, ethnic turmoil, and political upheaval.

IRVING E. HALL, M.D.
BRADENTON

Diabetes Detection

Dr. Glen W. McDonald, chairman of the Expert Committee on Diabetes for the World Health Organization and one of the speakers at the 13th Annual Seminar on Diabetes held in Jacksonville last year, estimates that there are over four million diabetics in this country today. In Chicago last month he stated that better than 300,000 new cases are being discovered each year, although only two thirds of the states have active detection programs.

In our state, through the combined efforts of the Board of Health, the Florida Diabetes Association and in some cases the diabetes committees

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of the county medical societies, thousands of new cases are being referred to the private physicians annually.

Diabetes Week, November 13-19 this year, is receiving more attention than ever before and, as

it is now the third cause of blindness and a major factor in accelerating what has been known as the aging process, it is commanding more and more private and federal research aid. Recent studies of this protean disease have resulted in more precise methods of diagnosis which indicate disease prior to the appearance of an abnormal glucose tolerance test. Present studies indicate that measurement of capillary basement membrane thickness may prove a reliable diagnostic procedure for early detection in the future. Dr. Marvin D. Seperstein, professor of medicine, University of Texas, Southwestern Medical School, Dallas, reports about 1200 Å for normal capillary basement membrane thickness, 1500 Å for his prediabetics and around 2500 Å for diabetics. Though his work has not been fully accepted, it is highly respected and very interesting.

The importance of early detection lies in the fact that it affords the physician the opportunity to avoid catastrophic illness such as acidosis and complications such as gangrene. Furthermore, in keeping with the present concept of prediabetes, chemical diabetes and clinical diabetes as a forward progressive illness, it means that such a process can be delayed and possibly reversed by good medical management and treatment, if it is rendered early in the disease.

The best screening test is still the blood sugar determinations made one and two hours after a high carbohydrate meal. Glucola or a Milky Way candy bar has proven to be a good substitute, and although there remain considerable individual inconsistencies the three hour oral glucose tolerance test continues to be the preferred retest method. Other diagnostic techniques include the cortisone-glucose tolerance test, the intravenous tolbutamide test and the intravenous glucose tolerance test.

Screening of high risk groups, of course, gives the highest yield. There is no race in which the disease does not exist, but environmental factors may influence its prevalence. For example, diabetes is uncommon in the Negro of West Africa

and yet his descendant, the American Negro, develops the disease more frequently than the American Caucasian. As Florida physicians, we should make a special effort to detect or rule out diabetes in our patients who have diabetic relatives, who are overweight—especially those over 40 years of age, and in mothers who have given birth to large babies. Diabetes should also be particularly sought out in those who have presenile cataracts, arteriosclerosis, cardiovascular disease and glaucoma.

The recent meeting of the Florida Diabetes Association in Miami with Drs. Cahill, Fajans, Krosnick, Miller, Seperstein and the endocrinologists of the state medical schools pointed up the need to interest more Florida physicians in the early detection of diabetes. The association's main purpose is dissemination of professional knowledge, education of the lay societies and providing a camp for the diabetic children of Florida.

A petition has been sent the governor of Florida asking he proclaim the week of November 13-19, 1966, which will be observed as National Diabetes Week, as Florida Diabetes Detection Week in recognition of the essential need for such detection to the common welfare of the citizens of this state.

If we as physicians will individually and carefully screen each patient for possible diabetes during this week alone, it will greatly add to the number being found by the State Board of Health screening program, and thereby afford a staggering number of additional healthy and serviceable years for our citizens. Diabetes mellitus, be it metabolic, vascular, collagen or autoimmune, is very much with us and seems ever on the increase. How many new cases did you discover this month?

MATTHEW E. MORROW, M.D.
PRESIDENT
FLORIDA DIABETES ASSOCIATION
JACKSONVILLE

against the usual gram-negative urinary pathogens

Why use five...where one will do?



In a recent 217-patient hospital study,¹ urinary tract infections were treated with a variety of widely prescribed antimicrobial agents including: a sulfonamide (40 patients), chloramphenicol (20 patients), nitrofurantoin (33 patients), nalidixic acid (30 patients), tetracycline (27 patients), colistimethate sodium (22 patients) ... and 2 combinations of 5 agents each (45 patients). The 2 combinations were selected to afford maximal theoretical antibacterial coverage against the usual urinary pathogens. They were (1) tetracycline, chloramphenicol, nitrofurantoin, ristocetin and polymyxin B; and (2) tetracycline, chloramphenicol, erythromycin, nitrofurantoin and colistimethate sodium.

This clinical study shows that the two combinations of antibiotics were not superior to some of their single components. The authors point out that antibiotic antagonism often negates theoretical advantages of multiple therapy. Coly-Mycin Injectable (colistimethate sodium) was one of the single components that was shown to be equal to the combinations and eradicated bacteriuria in two-thirds of the patients.

Theoretical choice of multiple antibacterial therapy has been shown to be no more effective than one well-chosen agent which also offers least patient exposure to possible side reactions, toxicities, allergic manifestations and higher drug costs.

1. McCabe, W. R., and Jackson, G. G.: New England J. Med. 272:1037, 1965.

in gram-negative urinary tract infections often the single well-chosen agent



Coly-Mycin® Injectable

(colistimethate sodium)

Indications: Especially indicated for the treatment of severe acute and resistant chronic urinary tract infections due to sensitive strains of gram-negative organisms. Also indicated in respiratory tract, surgical, wound and burn infections and in septicemia due to sensitive organisms. Particularly indicated when any of these infections are caused by sensitive strains of *Pseudomonas aeruginosa*.

Adverse Reactions: Occasional reactions such as circumoral paresthesias, tingling of the extremities, pruritus, vertigo or dizziness may occur. Reduction of dosage may alleviate symptoms. Therapy need not be discontinued, but such patients should be observed with extra care.

Warning: Patients should be cautioned not to drive vehicles or use hazardous machinery while on therapy.

Precautions: In cases of impaired or suspected renal impairment, use with greater caution and reduce dosage in proportion to extent of impairment. Transient elevations of BUN have been reported. As a routine precaution, appropriate blood studies should, therefore, be made during prolonged therapy.

As with all polypeptides, the possibility of muscular weakness, including apnea, due to inadvertent overdosage or normal dosage in the presence of impaired renal function, should not be overlooked. In cases of apnea, medication should be promptly discontinued and assisted respiration given until serum levels fall and normal breathing is restored.

Other antibiotics, such as kanamycin, streptomycin, dihydrostreptomycin, polymyxin, and neomycin, may also have varying neurotoxic or nephrotoxic potential. They should be used with great caution concomitantly with Coly-Mycin Injectable (colistimethate sodium).

For deep intramuscular injection only.

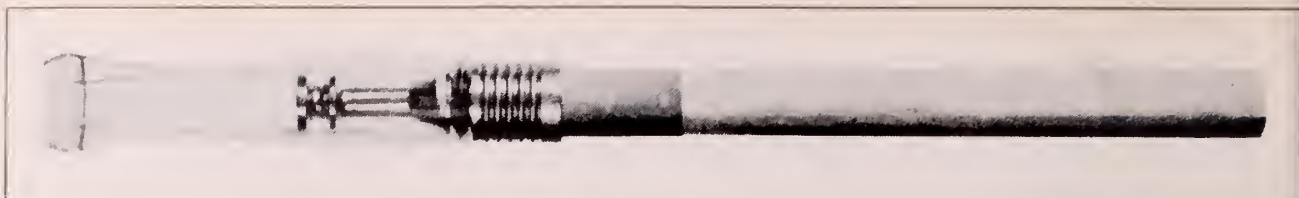
Dosage: By the I.M. route only, in 2 to 4 divided doses ranging from 1.5 to 5 mg./Kg./day (0.7 mg. to 2.3 mg./lb./day). Average adult dose is 2.5 mg./Kg./day (1.1 mg./lb./day). In the presence of bacteremia, septicemia, or other serious infection, greater than average doses may be required; however, maximum daily doses should not exceed 5 mg./Kg. (2.3 mg./lb.) where renal function is normal.

Not recommended against *Proteus*.

Colistin is also available (as colistin sulfate) in: Coly-Mycin® Pediatric for Oral Suspension (not for systemic use), and Coly-Mycin® Otic with Neomycin and Hydrocortisone.

Full information is available on request.





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If your cigarette-smoking patient could only see some of the tar in cigarette smoke, it could convince him to stop smoking. Let Tar Gard help. A Tar Gard demonstration in your office might be the meaningful nudge he needs to make him quit. All you have to do is give one of the Tar Gard demonstration units to your patient — have him smoke four cigarettes through the unique* Tar Gard filter holder. When he sees the amount of tar trapped and realizes that normally this would stay in the mainstream of the smoke — the smoke he inhales — this could prove to be the most dra-

matic visual proof of the health hazards of smoking. And when your patient multiplies the amount of tar captured from four cigarettes by the related number of cigarettes he smokes over a 365 day period,** he can draw his own conclusions as to whether the smoking habit is worth the price he might have to pay.

We would like to send you a Tar Gard demonstration unit. Simply fill in the coupon (or request on your letterhead) and mail to Tar Gard, 2 Pine Street, San Francisco, California.

*Technically, Tar Gard is not a filter. It is a patented tar trapping device based on the principle of the Venturi tube, such as is employed in the bedside respirator used in critical respiratory management, the vaporizer and the aspirator. In Tar Gard, as cigarette smoke is inhaled, the pressure energy of the tar-filled smoke is accelerated (to approximately 200 mph) and then stopped abruptly by an impingement barrier, where tars are trapped.

**In an independent study carried out by Curtis and Tompkins, Ltd., Analytical Chemists, San Francisco, it was recorded that over a one year period, using 20 cigarettes per day as a base, the average amount of tar trapped in Tar Gard was 0.29 lb. (high temperature tars)

Tar Gard Company, 2 Pine St., San Francisco, Calif. 94111

Please send me Tar Gard Professional Demonstration Unit.

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TAR GARD

Letters



September 13, 1966

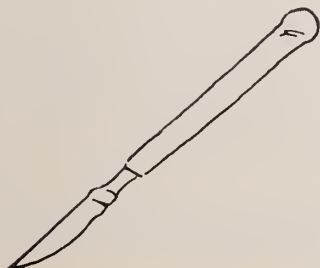
Dear Editor:

This letter should have been sent to you a month ago, but it is still not too late to commend you and your contributors for the outstanding August issue of the Journal. Not only did the historical articles make fascinating reading, but they also pointed up the independence and ingenuity of physicians in days when these were prime requisites for survival.

The history of medicine is fascinating in itself, but anecdotes and intimate stories of individual physicians always give the reader a sense of closeness and identification with this particular part of the past which makes him proud to be identified with this past.

In these hectic days of rapid change and new discoveries, all in the name of so called "progress," it is sometimes well to pause and look backward, to reflect and reminisce, and then look forward again more wisely and soberly. To do this "improves one's ability to see ahead," as you so eloquently stated.

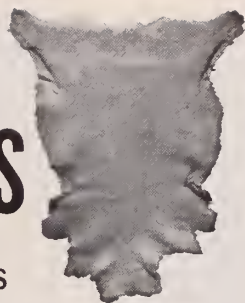
FRANKLIN J. EVANS, M.D.
CORAL GABLES



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(The Bacteriostat remains on the bedpad after laundering and inhibits bacteria growth)

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understanding... precedes development

The synthesis of cortisone was accomplished by Merck Sharp & Dohme in 1948—the famous “Compound E” used by Dr. Philip Hench in his historic experiment at the Mayo Clinic.

But proud as we are of our role in the development of cortisone and subsequent corticosteroids, we have continued to seek a greater understanding of arthritic disorders

and new drugs for their treatment.

One such drug—INDOCIN® (indomethacin), a nonsteroid, anti-inflammatory agent fundamentally different in structure and activity from other drugs in use—was recently made available for the treatment of arthritic conditions. It opens new possibilities for the long-term management of arthritis and inflammatory disease.



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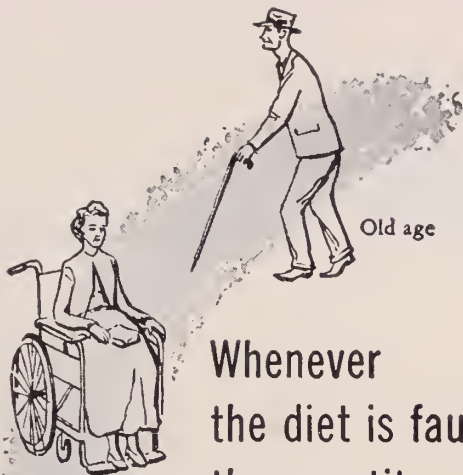
INDOCIN[®]

INDOMETHACIN

Indications: Chronic and acute rheumatoid arthritis, rheumatoid (ankylosing) spondylitis, degenerative joint disease (osteoarthritis) of the hip, and gout. **Contraindications:** Active peptic ulcer, gastritis, regional enteritis, or ulcerative colitis. Safety in pregnancy has not been established. Not recommended for pediatric age groups.

Warning: Patients who experience dizziness, lightheadedness, or feelings of detachment on INDOCIN should be cautioned against operating motor vehicles, machinery, climbing ladders, etc. Use cautiously in patients with psychiatric disturbances, epilepsy, or parkinsonism.

Precautions and Adverse Reactions: Most commonly, headache, dizziness, lightheadedness, G.I. disturbances. The C.N.S. effects are often transient and frequently disappear with continued treatment or reduced dosage. The severity of these effects may occasionally require cessation of therapy. G.I. effects may be minimized by giving the drug with food or with antacids or immediately after meals. Ulceration of the stomach, duodenum, or small intestine has been reported and, in a few instances, severe bleeding with perforation and death. Gastrointestinal bleeding with no obvious ulcer formation has also been noted; INDOCIN should be discontinued if G.I. bleeding occurs. As a result of G.I. bleeding, some patients may manifest anemia, and for this reason periodic hemoglobin determinations are recommended. Rare reports of effects not definitely known to be attributable to INDOCIN include bleeding from the sigmoid colon (either from a diverticulum or without a known previous pathologic condition), perforation of preexisting sigmoid lesions (diverticulum, carcinoma), and hematuria. In other rare cases, a diagnosis of gastritis has been made while the drug was being given. One patient developed ulcerative colitis, and another, regional ileitis, while receiving INDOCIN; when the drug was given to patients with preexisting ulcerative colitis, there was an increase in abdominal pain. Infrequently observed side effects may include drowsiness, tinnitus, mental confusion, depression and other psychic disturbances, blurred vision, stomatitis, pruritus, edema, and hypersensitivity reactions. Slight BUN elevation, usually transient, has been seen in some patients, although the preponderance of evidence indicates that INDOCIN does not adversely affect renal function, even in patients with preexisting renal disease. Nevertheless, renal function should be checked periodically in patients on long-term therapy. Leukopenia has been seen in a few patients. Transient elevations in alkaline phosphatase, cephalin-cholesterol flocculation, and thymol turbidity tests have been observed in some patients and, rarely, elevations of SGOT values; the relationship of these changes to the drug, if any, has not been established. As with any new drug, patients should be followed carefully to detect unusual manifestations of drug sensitivity. Before prescribing or administering, read product circular with package or available on request.



Old age

Convalescence



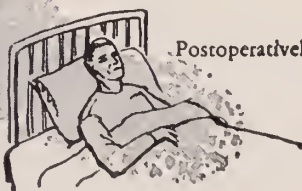
Adolescence



Infant diarrhea



Debilitating gastrointestinal conditions



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Whenever
the diet is faulty,
the appetite poor,
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is excessive

*through vomiting
or diarrhea—*

Valentine's MEAT EXTRACT

stimulates the appetite,
increases the flow of
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provides: supplementary
amounts of vitamins, minerals
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extra-dietary vitamin B₁₂,

protective quantities of
potassium, in a palatable and
readily assimilated form.

Supplied in bottles of 2 or 6 fluidounces.

DOSAGE is 1 teaspoonful two or three times daily; two or three times this amount for potassium therapy. Dilute with two or more equal volumes of water.

VALENTINE Company, Inc.
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Government News

AMA Emergency Medical Care Program

The American Medical Association recently announced plans for a program designed to bring about what was termed "a vast upgrading" of emergency medical care in the United States.

With hospital emergency room visits up 175% in a 10 year period, overall services and facilities "have fallen woefully behind," said Dr. Charles C. Edwards, director of the AMA's division of socioeconomic activities.

"The dramatic increase in emergency cases has not been matched with dynamic efforts for a vast upgrading of services," Dr. Edwards declared.

"We know that emergency service can be excellent. This has been proven in many communities. But there is no uniformity. In other areas emergency service suffers from both lack of coordination and lack of understanding about what constitutes good care.

"A soldier wounded in the jungle of Vietnam often gets quicker, more comprehensive emergency care than an accident victim on the open highway or a farmer stricken by a heart attack."

Acting on a recommendation of its Board of Trustees, the AMA has called together a panel of experts to help organize a national conference next spring that will study and recommend means for improving emergency medical care.

One of the principal tasks of the conference, said Dr. Edwards, will be to unify work already underway by such groups as the American College of Surgeon's trauma committee and the AMA's Council on Rural Health, department of health

education and department of hospitals and medical facilities.

As envisioned by Dr. Edwards, the conference will delve into four principal areas: Ambulance service and the training of ambulance personnel; the operation, staffing and equipping of hospital emergency facilities; improved medical education in emergency procedures, and further research into the causes and prevention of medical emergencies, whether the result of accident or disease.

"We are faced not with a single problem but with a complexity of problems," Dr. Edwards said. "These add up to the fact that nationwide too many emergency patients are dying from want of fast appropriate action—either because their would-be rescuers are inept or because care facilities are inadequate."

Most efforts to improve such conditions have run up against lack of incentive or lack of financing, Dr. Edwards noted. "This means that in a sense emergency service has been relegated by default to a sidelight instead of a vital function in overall medical care.

"At present we don't even know how many ambulances there are in the nation, let alone how many lives might be saved each year among hundreds of thousands of trauma patients if emergency care were better.

"In any event, it is time we found out what is possible through improved facilities and improved understanding of the nature of medical emergencies."



And now . . . for all you cold sufferers who've been looking for a cure-all.

They can't cure a cold. We can't cure a cold. You can't cure a cold. But what you can do is relieve the symptoms, making the patient comfortable and the cold bearable.

The patient suffering from head cold congestion, for instance, should breathe easier when you prescribe Novahistine LP. Novahistine LP is a long-acting decongestant that helps restore normal mucus secretion and ciliary activity—physiologic mechanisms which prevent infection of the respiratory tract. Two tablets in the morning and two in the evening will provide around-the-clock relief by helping to keep congested air passages clear, thus enabling your cold patient to enjoy normal and free breathing.

Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Tell patients who operate machinery or motor vehicles that drowsiness may result.

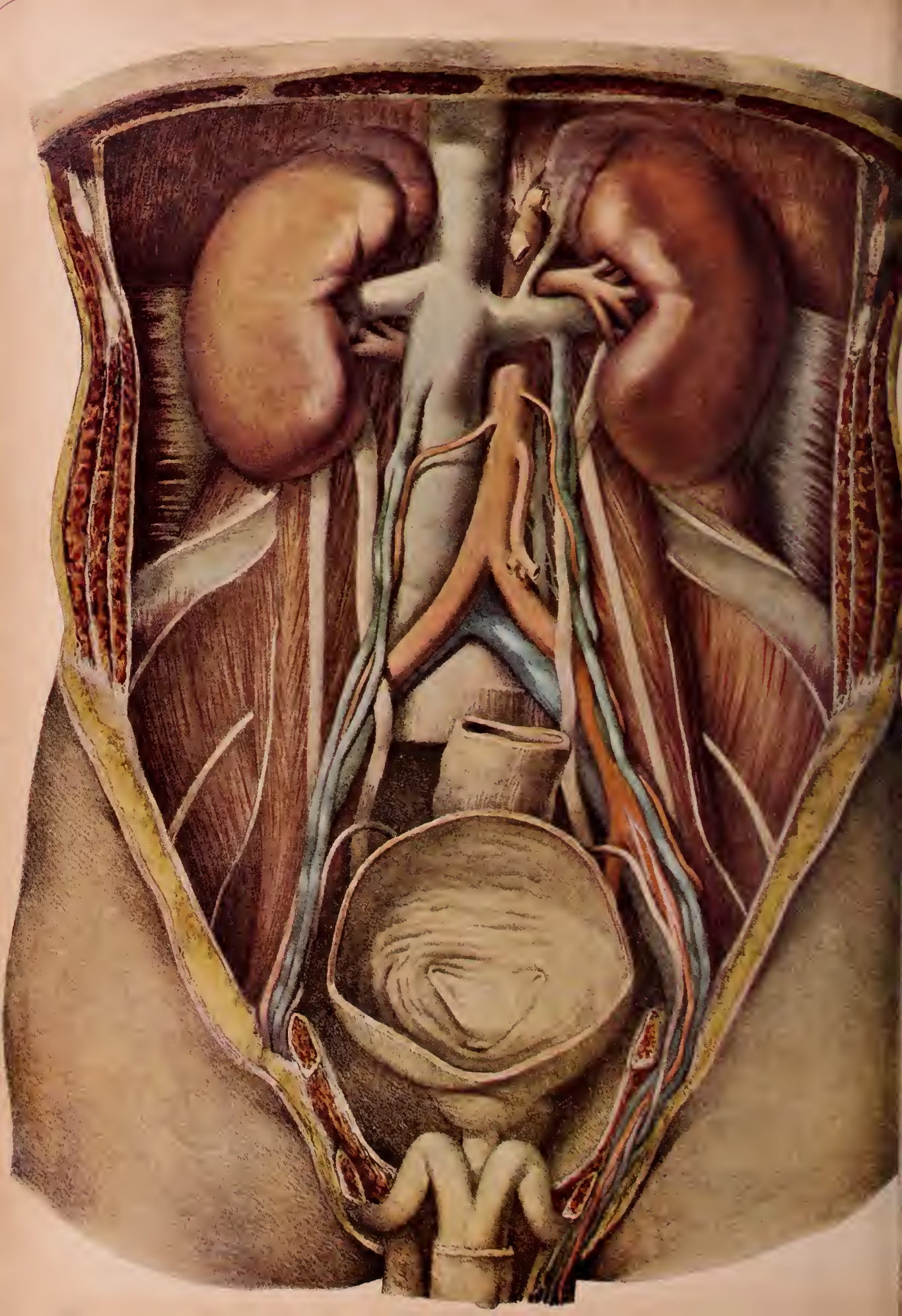
Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis

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NOVAHISTINE[®] LP

For relief of nasal congestion



Wide-range bactericidal action for genitourinary infections

NEW OMNIPEN[®] (AMPICILLIN) WYETH

A penicillin that exhibits effectiveness within the gram-positive spectrum of penicillin G* and the gram-negative spectrum of chloramphenicol and the tetracyclines.*

Active at foci of infections—kidney, ureter, bladder or urethra.

Effective against many gram-negative and gram-positive pathogens—thus may be valuable not only in genitourinary but also in common respiratory and gastrointestinal infections.

Normally produces high and persistent levels in blood and high concentrations in bile and urine.

Significant inherent stability.

**Exclusive of penicillinase-producing bacteria.*

Indications: Urinary tract infections, especially those caused by *E. coli*, *Proteus mirabilis*, and *Streptococcus faecalis* and *viridans*; respiratory infections caused by *H. influenzae*, pneumococci, streptococci, and nonpenicillinase-producing staphylococci; and gastrointestinal infections caused by *Shigella* and *Salmonella*, including *Sal. typhosa*.



Contraindications: Hypersensitivity to penicillin; infections due to penicillinase-producing staphylococci and other penicillinase-producing bacteria.

Precautions: If allergic reaction occurs, discontinue ampicillin and administer epinephrine, corticosteroids, antihistamines and/or pressor amines as indicated. Transient moderate

elevation of SGOT values of undetermined significance was noted in a few infants. Liver and kidney function as well as hematopoietic tests are advisable during therapy, particularly in infants. As with other antibiotics, precautions should be taken against gastrointestinal superinfection. Safety for use in pregnancy has not been established.

Adverse Reactions: Occasional mild side effects as urticaria, skin rash, pruritus, diarrhea, nausea and vomiting. There have been no reports of blood dyscrasias, liver or kidney damage. Anaphylaxis has been reported.

Composition: Capsules, 250 mg.
**American Hospital Formulary
Service Category No. 8:12.16.**

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DEXTRO-AMPHETAMINE SULFATE (15 mg.) SUSTAINED RELEASE CAPSULES
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Contraindications: Dextro-amphetamine sulfate: in hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.



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There is a growing senescent body of people on their way to malignant inactivity, who sorely need your interest and direction to help them back to a more active and useful life. There are medicines too, designed to help. One such has proved useful in clinical practice.

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McNeill, A. J.: Clin. Med. 8:518 (Mar.) 1961.

"Mediatrix (steroid-nutritional compound) capsules, one a day, seem to give definite help to debilitated patients."

Arnold, E. T., Jr.: Geriatrics 12:612 (Oct.) 1957.

"Nutritional and hormone bolstering of function in the aged may have a useful place in geriatrics."

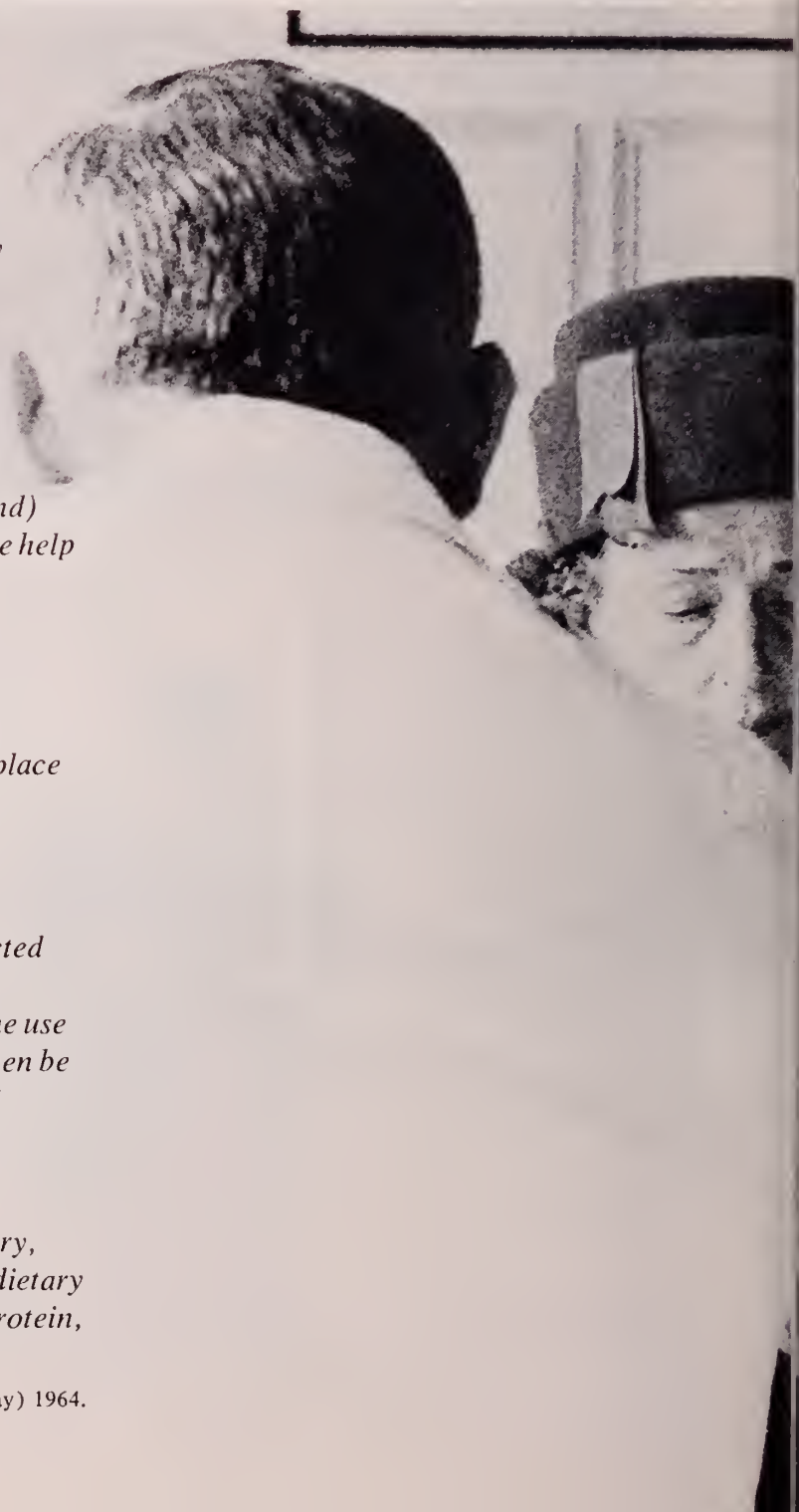
Morgan, A. F.: Gerontologist 2:77 (June) 1962.

"In diets which for any reason are restricted in calories, enough of these substances (B vitamins) may not be supplied ... The use of B and C vitamin supplements may then be justified and indeed may be necessary."

Morgan, A. F.: Gerontologist 2:77 (June) 1962.

"Intensive nutritional therapy is necessary, especially in elderly people, to correct dietary deficiencies created by large losses of protein, vitamins and other nutrients."

Riccitelli, M. L.: J. Am. Geriatrics Soc. 12:489 (May) 1964.



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Designed for the "metabolically spent"

Nutritional reinforcement for those who can't
—or won't—eat properly...balanced amounts of
estrogen and androgen to counteract declining
gonadal hormone secretion and its sequelae of
premature degenerative changes...mild
antidepressant for a gentle "mood" uplift...

The estrogen component in MEDIATRIC is
PREMARIN® (conjugated estrogens—equine),
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MEDIATRIC also provides *nutritional reinforcement—blood-building factors and vitamin supplementation*. It contributes a gentle "mood" uplift
through methamphetamine HCl.

Three different dosage forms—Liquid, Tablets, and
Capsules—offer convenience and variety.

MEDIATRIC Liquid

Each 15 cc. (3 teaspoonfuls) contains:

Conjugated estrogens—equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
Biotin	5.0 mg.
Cyanocobalamin	1.5 mcg.
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Contains 15% alcohol

MEDIATRIC Tablets and Capsules

Each MEDIATRIC Tablet or Capsule contains:

Conjugated estrogens—equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
Ascorbic acid	100.0 mg.
Cyanocobalamin	2.5 mcg.
Intrinsic factor concentrate	8.0 mg.
Biotin mononitrate	10.0 mg.
Riboflavin	5.0 mg.
Thiaminamide	50.0 mg.
Ethiodoxine HCl	3.0 mg.
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Orally active, water-soluble conjugated estrogens derived from
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MEDIATRIC helps keep the older patient alert and active;
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usually associated with declining gonadal hormone secretion.

CONTRAINDICATION: Carcinoma of the prostate, due to methyl-
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WARNING: Some patients with pernicious anemia may not
respond to treatment with the Tablets or Capsules, nor is
cessation of response predictable. Periodic examinations and
laboratory studies of pernicious anemia patients are essential
and recommended.

SIDE EFFECTS: In addition to withdrawal bleeding, breast ten-
derness or hirsutism may occur.

SUGGESTED DOSAGES: *Male and female:* 3 teaspoonfuls of
Liquid, 1 Tablet, or 1 Capsule, daily or as required.

In the female: To avoid continuous stimulation of breast and
uterus, cyclic therapy is recommended (3 week regimen with
1 week rest period—Withdrawal bleeding may occur during
this 1 week rest period).

In the male: A careful check should be made on the status of
the prostate gland when therapy is given for protracted
intervals.

SUPPLIED: No. 910 — MEDIATRIC Liquid, in bottles of 16
fluidounces and 1 gallon. No. 752 — MEDIATRIC Tablets,
in bottles of 100 and 1,000. No. 252 — MEDIATRIC Cap-
sules, in bottles of 30, 100, and 1,000.

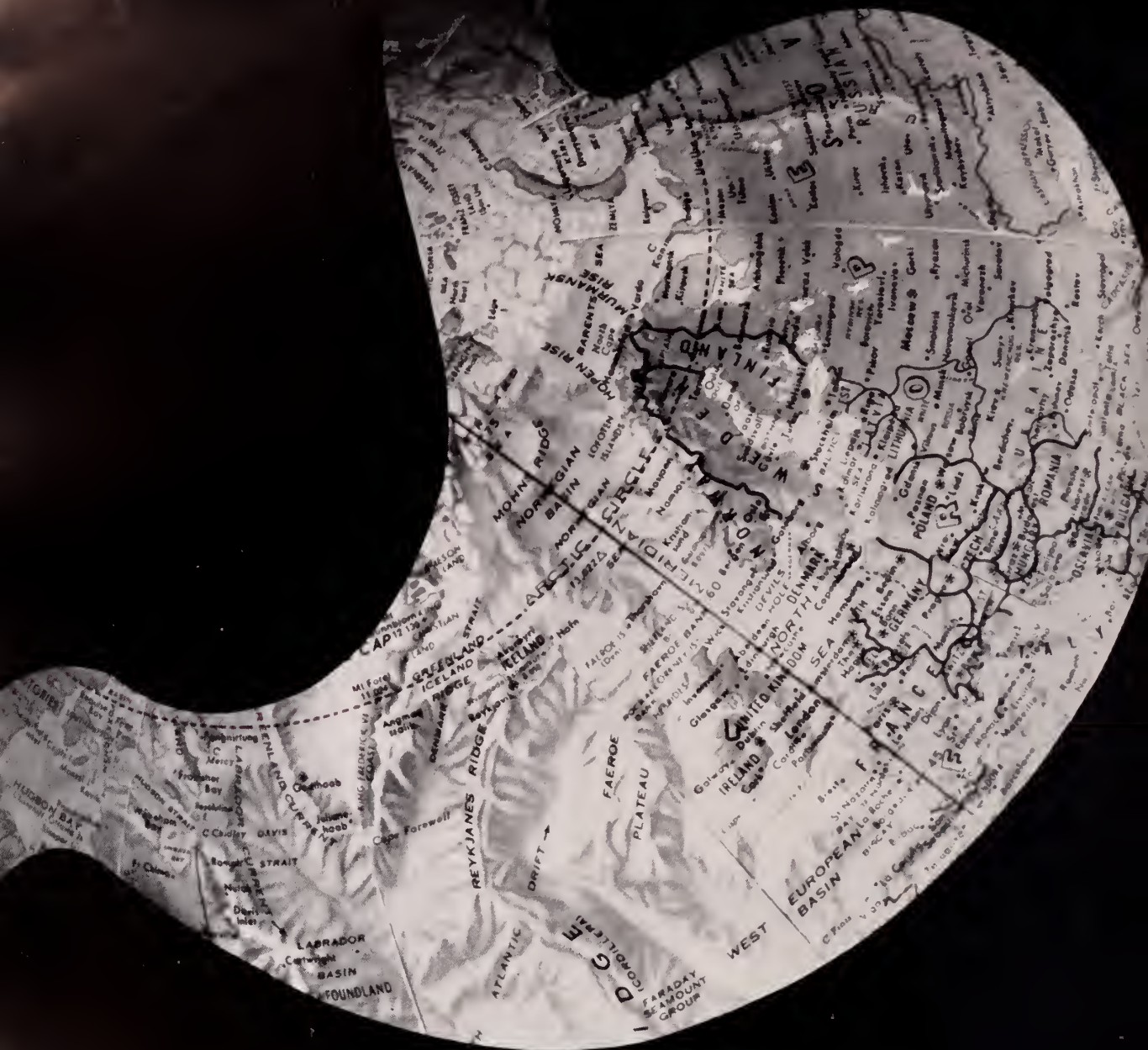


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The “Socio- geographic” mystery

Why is one man's gastric ulcer another man's duodenal?



Geographic variation in the *incidence* of peptic ulcer is a familiar fact. But the proclivity of certain *kinds* of ulcer for certain geographic areas is a recently recognized phenomenon.^{1,2}

For example, in one particular Norwegian fishing village there is a tendency for patients to develop a gastric ulcer; anywhere else in Norway, ulcers are usually duodenal. Peruvians high in the Andes have more gastric ulcers than their compatriots in the lowlands. Why? Nobody knows.

Social variations, too. Even in the same geographic areas there are interesting variations. An Englishman's ulcer depends on his social standing—professional men suffer with duodenal ulcers, while workingmen have more of the gastric variety. In southern India the pattern is reversed. Here, duodenal ulcers are common among laborers and agricultural workers and rare among the upper classes. Investigators are exploring every possible theoretical avenue in their search for the cause of peptic ulcer. Of all the factors implicated in ulcerogenesis, the one that is generally acknowledged to be of primary importance is hypersecretion of gastric acid.³⁻⁸ Or, as one author states it: "The medical management of peptic ulcer pharmacologically is, in the final analysis, concerned largely with the effective inhibition of peptic activity."³

Robinul (glycopyrrolate) provides potent, rapid, specific antisecretory action as confirmed by gastric analyses and x-ray evidence of clinical effectiveness.^{3,7,9-12} It relieves pain with "impressive" promptness.⁸ Quickly alleviates acute discomfort, and effectively counteracts gnawing pain, preprandial midepigastric pain, burning and other ulcer symptoms.⁷ Suppression of nocturnal pain is "outstanding."¹³ Maximally effective doses may be given with minimal side effects, and the incidence of unwanted anticholinergic effects is negligible.^{3,7-14}

No matter what the ulcer theory...the fact is that

Robinul[®]

(glycopyrrolate)

Promotes the essential ulcer-healing environment

H. ROBINS

(brief summary follows)

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Robinul® (glycopyrrolate)

**promotes the
essential ulcer-healing
environment**

Indications: In addition to its primary indications for duodenal and gastric ulcer, Robinul (glycopyrrolate) is indicated for other GI conditions that may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.

Contraindications: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.

Precautions: Administer with caution in the presence of incipient glaucoma.

Adverse Reactions: Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

Dosage: Dosage should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet 3 times a day: in the a.m., early p.m., and at bedtime. *See product literature for full prescribing information.*

Supply: Robinul (glycopyrrolate 1 mg.); Robinul Forte (glycopyrrolate 2 mg.); Robinul-PH (glycopyrrolate 1 mg.) with phenobarbital 16.2 mg. (Warning: May be habit-forming); Robinul-PH Forte (glycopyrrolate 2 mg.) with phenobarbital 16.2 mg. (Warning: May be habit-forming.) In bottles of 100 and 500 scored tablets.

References: 1. Jones, F. A., and Gummer, J. W. P.: Clinical gastroenterology, Springfield, Ill., Charles C Thomas, 1960, pp. 322-3. 2. Bockus, H. L.: Gastroenterology, 2nd ed., vol. I, Philadelphia, Saunders, 1963, p. 468. 3. Sun, D. C. H.: Ann NY Acad Sci 99:153 (Feb. 28) 1962. 4. Moore, V. A.: Postgrad Med 38:216 (Sept.) 1965. 5. Dragstedt, L. R., Woodward, E. R., Storer, E. H., Oberhelman, H. A., Jr., and Smith, C. A.: Ann Surg 132:626 (Oct.) 1950. 6. Posey, E. L., Jr., Smith, P., Turner, C., and Aldridge, J.: Amer J Dig Dis 10:399 (May) 1965. 7. Lamphier, T. A., Siegel, L., and Goldberg, R. I.: Amer J Gastroent 37:551 (May) 1962. 8. Kasich, A. M., and Fein, H. D.: Ibid 39:61 (Jan.) 1963. 9. Epstein, J. H.: Ibid 37:295 (Mar.) 1962. 10. Moeller, H. C.: Ann NY Acad Sci 99:158 (Feb. 28) 1962. 11. Slinger, A.: J New Drugs 2:215 (Jul.-Aug.) 1962. 12. Barman, M. L., and Larson, R. K.: Amer J Med Sci 246:325 (Sept.) 1963. 13. Shutkin, M. W.: Amer J Gastroent 38:682 (Dec.) 1962. 14. Flesher, B.: J New Drugs 2:211 (Jul.-Aug.) 1962. A. H. ROBINS CO., INC. Richmond, Virginia

The discomforts of
**DIARRHEA
MUCOUS COLITIS
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*are relieved by
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Available in 100 milligram pink sugar-coated tablets.

The high therapeutic index permits dosage sufficient to relieve spasm promptly.

Administer 4 tablets every 4 hours until relief is constant, then adjust maintenance dosage.

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*Directly relaxes smooth muscle spasm
Combats hypermotility
Non-mydriatic, may be used in glaucoma*

Sixteen years of clinical use, with absence of untoward effects, has established the safety and effectiveness of Trocinat.

Trocinat is metabolized in the body and completely eliminated, which is a safety factor. Dosage must be sufficient to maintain the therapeutic blood level.

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The Medical Detective



Danger in a Familiar Package

Many, many accidents have occurred, some with fatal outcome, as the result of poisonous or harmful substances being placed in bottles, jars or other packages which have a harmless association.

One such accident occurred in a large hospital where a young laboratory technologist, who had been on the job for a short time, was asked to perform a glucose tolerance test on an outpatient. She went into the refrigerator in the chemistry laboratory and took a plastic container of the type that contained the glucose solution from the shelf. After drawing the base-line sample she gave the patient the thick colorless solution. She stepped out for a moment and returned to find the patient cyanotic and soap bubbles were foaming from his lips. She smelled the solution which she had poured and given to the patient and, lo and behold, it was apparently a liquid detergent. The patient was rolled into the emergency room immediately and the resident pumped out his stomach. He was in shock at first, but after a day he responded and was able to return to his home with no apparent harmful effects.

This accident was investigated and the prob-

lem was obvious. Someone had used an empty glucose solution container as a receptacle to hold the detergent and had not removed the label "Glucose Solution"—thus the outcome. Putting the detergent container on the same shelf was apparently force of habit by a technologist who saw this container where the person using it had left it.

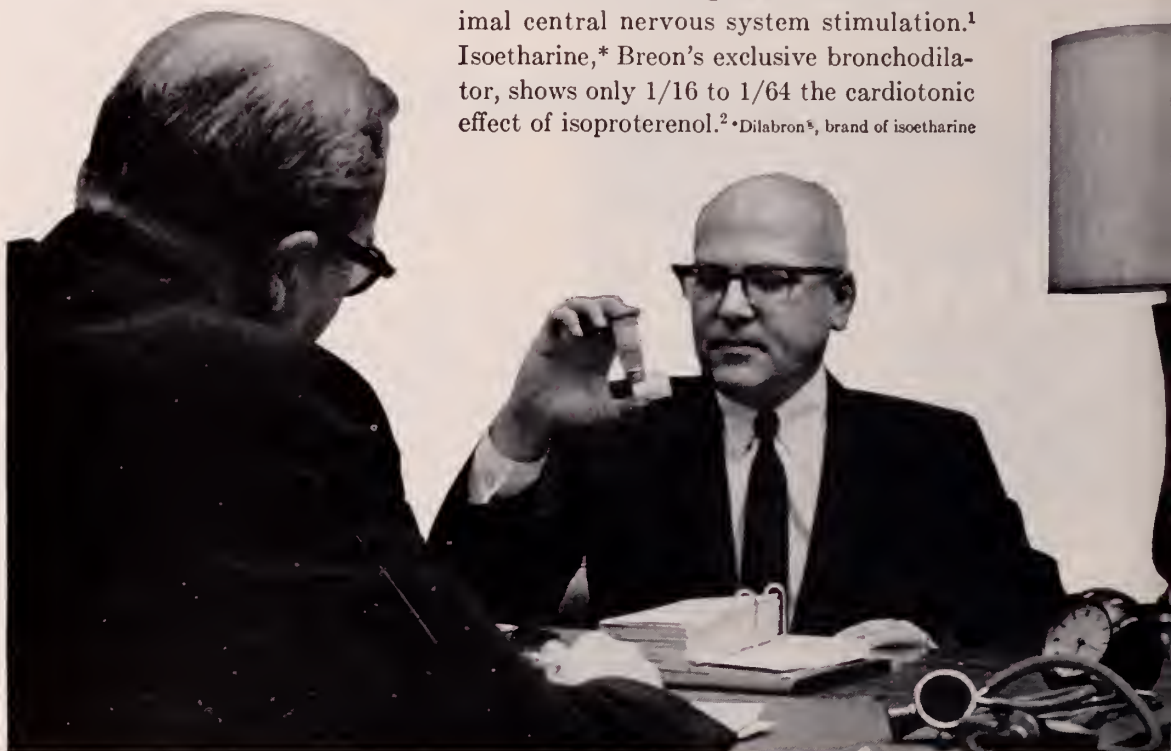
Similar accidents have occurred in hospitals where infusion bottles are used again for other than the usual use and solutions of similar color and consistency are placed in them. Coke bottles have been reused to hold kerosene, turpentine and pine oil solution and many children have been poisoned because they were familiar with the bottle's usual contents. Two deaths from thallium poisoning resulted from children eating the contents of a mustard jar baited to kill insects.

These are obvious and easily corrected errors which we as physicians can help to prevent by warning our patients of this potential hazard and seeing that our hospitals have adequate and active safety committees constantly on the alert for potential accident situations.

WILLIAM G. ECKERT, M.D.

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Patients feel relaxed with Bronkometer. Its bronchodilator-decongestant action has minimal central nervous system stimulation.¹ Isoetharine,* Breon's exclusive bronchodilator, shows only 1/16 to 1/64 the cardiotoxic effect of isoproterenol.² *Dilabron®, brand of isoetharine



BRONKOMETER® ASTHMA, CHRONIC BRONCHITIS, EMPHYSEMA

isoetharine 0.6%; phenylephrine 0.125%; thenyldiamine 0.05%—Superior because it contains isoetharine

COMPOSITION: Bronkometer delivers at the mouthpiece 200 metered doses of: 350 mcg isoetharine methanesulfonate (0.6%); 70 mcg phenylephrine HCl (0.125%); and 30 mcg thenyldiamine HCl (0.05%) with saccharin, menthol and fluorochlorohydrocarbons as inert propellants. Preserved with ascorbic acid 0.1% and alcohol 30%.

RECOMMENDED DOSAGE: One or two inhalations with at least one minute between inhalations. Occasionally more may be required, however in most cases, inhalations need not be repeated more than every four hours. Dosage should be adjusted to the severity of the condition and to patient's response.

PRECAUTIONS: Bronkometer is unusually free from cardiovascular and other side effects, but the usual precautions associated with sympathomimetic amines should be observed. Bronkometer should not be administered simultaneously with epinephrine or similar compounds because of the possibility of tachycardia, although it may be alternated with these agents. Dosage must be carefully adjusted in patients with hyperthyroidism, hypertension, acute coronary disease, cardiac asthma, limited cardiac reserve and in individuals sensitive to sympathomimetic amines.

SUPPLIED: 10 ml pressurized aerosol vials complete with measured dose valve and oral nebulizer.

References: 1. Spielman, A. D.: *Curr. Therap. Res.* 3:235 (June) 1961. 2. Herschfus, J. A.; Bresnick, E.; Levinson, L.; and Segal, M. S.: *Ann. Allergy* 9:769 (Nov.-Dec.) 1951.



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keeps pressure down

Advantage: Both components of Regroton are long-acting.

Average dosage: One tablet daily with breakfast.

Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.

Warnings: Discontinue 2 weeks before general anesthesia, 1 week before electroshock therapy, and if depression or peptic ulcer occurs. With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.

Precautions: Reduce dosage of concomitant antihypertensive agents by one-half. Discontinue if the BUN rises or renal dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, OTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.

Side effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness. For full details, see the complete prescribing information.

Availability: Bottles of 100 and 1000 tablets.

Geigy



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it take her
to recover from
her hip fracture
if she just
doesn't care?**



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Is she alert, encouraged,
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without getting completely
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of confinement, disability
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Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%; pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin B₁) (10 MDR*), 10 mg.; riboflavin (vitamin B₂) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin B₆), 1 mg.; niacinamide (5 MDR), 50 mg.; choline,[†] 100 mg.; inositol,[†] 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.

[†]The need for these substances in human nutrition has not been established.

Indications: 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

Contraindications: As with other drugs with CNS stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive compulsive states.

Side effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

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for broad-spectrum activity
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Whenever tetracycline is indicated in these candidates for Candida

1. diabetic patients



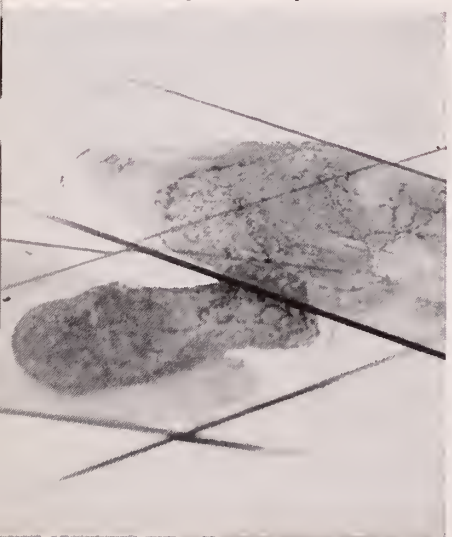
2. nonpregnant women with a history of recent
or recurrent monilial vaginitis



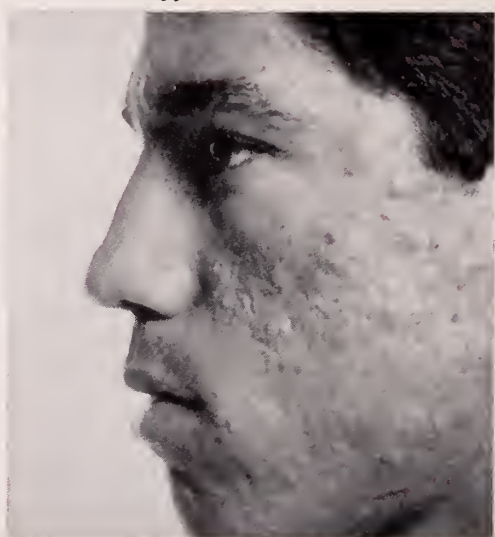
3. elderly or debilitated patients



4. patients with a past history of moniliasis



5. patients on long-term tetracycline or cortico-
steroid therapy



BRISTOL THERAPEUTIC SUMMARY: For complete information consult Official Package Circular. **Indications:** Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. **Contraindications:** The drug is contraindicated in patients hypersensitive to its components. **Warnings:** Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discoloration occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, low doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). **Precipitation:** Bacterial superinfection may occur. Infants may develop increased intracranial pressure with bulging fontanelles. Gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. **Reactions:** Glossitis, stomatitis, nausea, diarrhea, vaginitis, proctitis, vaginitis, dermatitis, and allergic reactions may occur. **Usual Adult Dosage:** 1 capsule q.i.d. Continue therapy for 10 days in beta-hemolytic streptococcal infections. Administer one hour before or 2 hours after meals. **Supply:** Capsules, bottles of 16. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin.

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Tetrex-F®

Each capsule contains tetracycline phosphate complex equivalent to tetracycline hydrochloride 250 mg. and nystatin 250,000 units.

Tetrex-F is priced lower
than most
tetracycline-antifungal products.

Others Are Saying



The Travel Industry

I address myself to all physicians who from time to time advise patients to get away for a while, or who themselves manage to break out of the heavily guarded circle of medical practice and take a short vacation.

What concerns me is the tremendous growth in travel, or tourism as it is more appropriately called. This has become one of the most significant social phenomena of our time. Indeed it has attained the proportions of an epidemic disease. The name of this disease is *travelitis furiosus*. It is carried by the organism called prosperity and is due to a highly contagious virus which is intensified by jet propulsion. There is a seasonal incidence—the main outbreak in high summer, with a lesser wave in mid-winter. Whereas there is a similar virus which affects lemmings which once a year rush in hordes from their settled habitation, in the human species there is a semi-annual dispersion. The prodromal symptoms may be seen in an intense restlessness which causes people to agglutinate in the offices of tourist agencies, to indulge feverishly in the purchase of apparel not indigenous to their habitat, and to haunt camera shops where they acquire all sorts of impedimenta.

When the disease reaches its height, there is the spectacle of hordes of people pushing about in every direction, like a number of confused armies

in combat on a vast dusty plain. The resulting babel of voices and tongues surpasses anything the ancient Tower of Babel ever experienced. As the epidemic subsides, the sufferers from the disease, called by epidemiologists "tourists," return to their separate places in a physically and financially exhausted state. Convalescence is marked by a curious urge to show to their families and circles of friends a vast array of colored slides—a medley compounded of shots of Trafalgar Square with pigeons, the Piazza San Marco with pigeons, the Arc de Triomphe without pigeons, the Leaning Tower of Pisa with wives or siblings. All this is interspersed with echoes of the recent delirium—how bad the water is in France, how good the wine is in Florence, how exciting a bull fight is, what poverty and dirt there is abroad, and so on. Finally, it may be noted that the disease confers a partial immunity. It may occur again, but never in such a virulent form.

I hope that I shall not be accused of being too harsh in what I have set down. What I am concerned about is that that particular healthy activity known as *travel* does not become devitalized or stilled by this folk-disease of tourism. Just how the exercise of travel may be safeguarded and preserved in the face of this global disease is becoming very much of a problem, and the solution must be worked out by each individual anxious to secure the real benefits of travel and

Reprinted from Group Practice (The Medical Jackdaw), July 1966.

avoid the pernicious influences of this pervasive contagion and its resulting frustration. Of course certain cardinal tips can be followed: avoid peak seasons; pick on certain places and visit them during off-hours; get off the beaten track; study an itinerary and plan carefully ahead of time; when possible, have friends or residents in the places to be visited put you on to "the ropes." For the rest, we can probably get this whole business into perspective by discussing some of the broad principles and features of travel. Reflection on these matters should assist one in charting a practical course.

Tourism

Turning our backs firmly upon the highly colored advertising lures of tourism, suppose that we first get out of the way two widely held propositions about travel. The first is that travel broadens the individual. This is not necessarily so. It overlooks the fact that you and I bring back from a journey to far places only what we take with us. The second is that travel contributes to the understanding of other people and in so doing increases good will. A sufficient answer to this idea would seem to be to look about the contemporary world scene which is far from being a setting of human concord. On the contrary, all this coming and going of peoples seems to have increased the apparent chaos of world relations. It is just possible that failure to build bridges of understanding is due to the failure of travel as presently practiced to offer anything really worth while to this end. This may be due to the nature in which the enterprise of travel in mass fashion is undertaken: it is a form of entertainment and escape; it is blighted by being commercialized; it is organized, whereas rewarding travel with intervals of leisure cannot be regimented like a military campaign.

In these matters each one should draw up his or her own blueprint for journeying, if possible taking plenty of time about it, and thus enjoying the anticipation and the fun of reading and thinking about the places you are planning to see. Travel, let it be said plainly, is an individual, not a group enterprise.

Without intruding further with what is only too often irrelevant and impertinent advice, let me set down, quite at random, some reflections on

travel which have formulated themselves in the mind of the writer over the years.

Travel serves to fill out the meaning of space or places with something of their substance in time and its human content.

The wonder of the world resides in him who sees it.

In travel we are not the same but another person, and perhaps for the time being (we hope) more ennobled individuals, all the time we are out of our own country. We are lost to ourselves as well as to our friends at home. Hence the remark after our return: "Are you getting settled down?"

As Hazlitt once said, things near us are seen the size of life, things at a distance are diminished to the size of the understanding.

The best of journeys leads us not only outward in space, but inwards as well. The best kind of travel can be one of the most rewarding forms of introspection.

In travel one does well to collect moments and places which later, from time to time, can be unpacked from memory and enjoyed at leisure. In this regard one thinks of those places or those works of art that have produced a few instants of complete harmony, experiences that suspend time and circumstance—such things as the delicate blue of a jacaranda tree in full bloom on the island of Corfu, a grove of grey-green olive trees near Delphi, the Parthenon suspended above the dusty city of Athens, a sunset off Rhodes, the mutter of history at Mycenae, the octagonal room of the Prado in Madrid containing the Velasquez pictures, the misty silences of Connemara in Ireland, the canals of Amsterdam in early morning, the city of Florence seen from Fiesole.

Piety for the Past

The proper attitude in travel might be stated something as follows. As far as ancient places are concerned, looking at them with imagination and wonder and posterity's small prerogative of gentle irony; with modern sights and places, looking at them with understanding, a sense of perspective, and an appreciation of the future. It is a fancy of mine that before places connected with great events or persons of history, one should exercise the ancient Roman virtue of *pietas*, a sense of regard and reverence. *Pietas* is a shared virtue, the love of things that have been loved before by

better men and women than ourselves, those things that proclaim the glory and the mortality of man. A touch of such piety before a broken memorial or a centuries-old masterpiece makes us infinitely more human.

And when the whole business is over and you sit beside your fireplace, what, you may ask yourself, is the ultimate gain of travel? Surely the fact that you have transformed into internal capital the tremendous flux of sensory impressions that you have gained in the course of your wanderings.

Let me give this discussion another twist by reminding ourselves that this travel that we have been talking about is the modern form of the ancient custom of going on pilgrimage. In the Europe of the Middle Ages pilgrimages were undertaken for spiritual reasons, for purposes of health, for adventure. Even today one can see the remains of the ancient routes—the Pilgrims' Way leading to Canterbury in Britain, the various roads to Rome in Northern Italy. Such pilgrimages had certain advantages—they were committed to some objective and were not just idle sightseeing, they were planned before-hand, they were designed to take the individual out of himself. It was a good custom on which our fore-

fathers placed great stock.

It might not be a bad idea, therefore, for the individual of today to think of his forthcoming travel jaunt as a pilgrimage. Conceived in this way, the journey is more than a holiday. A holiday (the French *vacances*) is good, but a pilgrimage is better, just as walking on Rannock Moor in Scotland is better than dashing through the moors and passes of that enchanted country in an automobile. A pilgrimage is not as careless as a holiday; it has some sense of a purpose about it. The pilgrim makes a sort of appointment with himself, with time, and, if he is fortunate, with history. He is doing what the race of men have done for a thousand years. The best books in the world are records of pilgrimages—the *Odyssey*, the *Aeneid*, the *Divine Comedy*, *Don Quixote*, the *Pilgrim's Progress*. And, if it comes down to that, we are all in this world on pilgrimage.

So next time you set out on travel, do not let the commonplace or the conventional trap you. Resolve that you will make the journey a tiny pilgrimage, a rewarding adventure, a glowing parenthesis in the larger dusty journey of life.

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Dear Dr. Leon Manheimer

Editor's Note: The Journal is pleased to publish the following poem as one of a series dedicated to her various physicians by Mrs. Leona Levin, a retired schoolteacher of Miami Beach who has been crippled by arthritis. Mrs. Levin writes under the pen name of Lena Lin Louis. The poems are presented as examples of all-too-rare expressions of gratitude to physicians. The doctors whose names appear have granted permission for their use.

T. M.

I am writing to you in this familiar vein
To thank you for the many times you relieved
us from pain.

You always gave us of your best,
Your patient explanation and assurance
put our worries at rest.

Thyroid removing, tumors exporting, internal
face lifting, intestinal obstruction defecating,
Nervous system recreating.

You have been lauded by many I know
From your teachings young aspirants grow.

So our future generation will reap the best,
As we are now so greatly blessed.

We'll never forget we are greatly in your debt,
Your patience with us we pray you will never
regret.

You are the star actor on our roster,
Your masterly performance deserves an Oscar.

It is said "Behind a great man, there is always a
good wife,"

Knowing your Sylvia, I know there is much
joy and love in your life.

Lena Lin Louis
Corny but sincere

This "case history" runs to some 10,000 pages

This is a typical "case history" of one new drug—or, rather, a proposed new drug—assembled for submission to the U.S. Federal Food and Drug Administration. These volumes are the result of several years' work by thousands of professional and skilled personnel in just one pharmaceutical company's research laboratories, and by hundreds of physicians in medical schools, hospitals, and private practice. They cover every aspect of experience with this proposed new agent from chemical laboratory to clinic, from mouse to man. Each volume could conceivably represent hundreds of thousands of dollars of financial invest-

ment, countless hours of human effort. This veritable mountain of data stands behind every new agent offered to you by pharmaceutical manufacturers—a reassuring testimonial to the efficacy, safety and purity of the drugs you will prescribe today to lower the cost of disease to your patients.



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This message is brought to you as a courtesy of this publication on behalf of the producers of prescription drugs.

"'Tranquilizer' is not a good word"

"THIS classification is psychologically too seductive, pharmacologically too unspecific, and in terms of results not infrequently untrue."²

What is a tranquilizer? According to the 24th Edition of Dorland's Medical Dictionary³ a tranquilizer is "an agent which acts on the emotional state, quieting or calming the patient without affecting clarity of consciousness."

Defining a drug by its effects, however, can be misleading. The same effects by which the dictionary defines a tranquilizer have sometimes been seen after administration of a sedative — or, for that matter, a placebo.

Ambiguous though the term may be, it appears to be here to stay. The 1966 edition of the Physicians' Desk Reference⁴ lists 42 tranquilizers indicated for treatment of anxiety and apprehensive states.

'Tranquilizers' have differences in action, differences in effect

Although all tranquilizers are intended to calm anxious patients there are differences in their actions — and in their effects. They have been divided into three categories — the rauwolfia group, the 'minor' tranquilizers, and the phenothiazines.⁵

Although the tranquilizing effect of rauwolfia has been known for centuries, its use as an antipsychotic agent in current practice has diminished.⁵

A 'minor' tranquilizer is often prescribed to achieve more than one effect. Thus, besides being tranquilizers some of these compounds may be muscle relaxants, antihistaminics with some calming action, anticholinergic sedatives, or antispasmodics.⁵

The phenothiazines are considered 'major' tranquilizers because they alter psychotic behavior.¹ This classification may have done them more harm than good because it implies that the phenothiazines should be reserved for the more

severely disturbed. This is not necessarily true.

The phenothiazines — and the problem of sedation

One of the problems of prescribing phenothiazines for ambulatory patients has been the fear that excessive sedation will impair the patient's ability to function. This, however, is less of a problem with some of the phenothiazines.

"Clinically they may be differentiated primarily in terms of their potency and the extent of their sedative effect, which appear to be inversely proportional. That is, the least potent, the one which is used in highest dosage, chlorpromazine, is the most sedative, while the reverse holds true for fluphenazine."⁶

In a recent report on various studies conducted over several years evaluating 360 patients treated for anxiety and stress with seven phenothiazines, this inverse relationship of potency to sedation was confirmed.⁷ Also under consideration was the degree to which the particular phenothiazines neutralized anxiety (the angolytic index). Interestingly enough there was, again, an inverse relationship. The most sedative of the phenothiazines appeared to be the least active in neutralizing anxiety. Fluphenazine, one of the least sedative, on the other hand, was found to be most effective in relieving anxiety.⁷

phenazine, one of the least sedative, on the other hand, was found to be most effective in relieving anxiety.⁷

RELATIVE SEDATIVE AND ANGOLYTIC INDICES OF PRINCIPAL PHENOTHIAZINES*

DRUG	SEDATIVE INDEX	ANGOLYTIC INDEX	BASED ON STANDARD DOSE OF
Chlorpromazine	100	15	25 mgs.
Trifluorpromazine	100	15	25 mgs.
Thioridazine	90	17	25 mgs.
Perphenazine	15	25	4 mgs.
Carphenazine	25	25	25 mgs.
Trifluoperazine	3.3	95	2.0 mgs.
Fluphenazine	3.5	100	2.5 mgs.

*adapted from Sainz⁷

Prolixin is therapeutically effective without excessive sedation

When used as a 'tranquilizer' in general medical practice, in many patients Prolixin (Squibb Fluphenazine Hydrochloride) suppresses anxiety, but not normal activity. These two features are of particular importance to patients who must be able to live and work without their normal daily activities being restricted.

Because of its longer duration of action, Prolixin, in doses of as little as one to three milligrams in adults generally taken once a day, is effective in maintaining many patients free of their symptoms of anxiety and tension.

Contraindications: Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use with caution in patients with a history of convulsive disorders. Severe reactions may occur in patients with idiosyncrasy to other centrally-acting drugs, and severe hypotension may occur in patients with special medical disorders, e.g. mitral insufficiency and pheochromocytoma.

Precautions: Effects of atropine, anesthetics and C.N.S. depressants may be potentiated. Hypotension may occur in patients undergoing surgery. Do not use epinephrine for treatment of the hypotensive reactions which may appear in patients on phenothiazine therapy.

Side Effects: Extrapyramidal reactions, allergic skin reactions, the possibility of anaphylaxis, drowsiness, visual blurring, dizziness, insomnia, nausea, anorexia, salivation, edema, perspiration, dry

mouth, abnormal lactation, polyuria, hypotension and jaundice and biliary stasis may occur. Routine blood counts are recommended to determine possible blood dyscrasias; if symptoms of upper respiratory infection occur, discontinue drug and institute appropriate therapy.

Available: 1 mg. tablets. Bottles of 50 and 500.

For full prescribing information, see package insert

References: 1. Simpson, G.M.: Postgrad. Med 39:557, 1966. 2. Freyhan, F.A.: Am. J. Psychiat 115:577, 1959. 3. Dorland's Illustrated Medical Dictionary, ed. 24, Philadelphia, W. B. Saunders Co. 1965, p. 1603. 4. Physicians' Desk Reference, 1966. 5. Oradell, N.J., 1965, p. 310. 6. Cohen, S.: Northwest Med.: 65:197, 1966. 7. Detre, T., and Jarecki, H. Connecticut Med. 25:553, 1961. 7. Sainz, A.: Psychosomatics 5:167, 1964.

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Association News



Board of Governors Meeting September 22-24

1967 Annual Meeting.—Adopted the format for the 1967 annual meeting to be held at the Americana Hotel, Miami Beach, May 11-14. The same basic format will be followed as in 1966, with the exception that all Reference Committees will begin their meetings at 2:00 p.m. on Thursday, May 11, and the Chairman of the Scientific Work Committee has been authorized to present a symposium on Medical Socio-Economic Programs.

Directory.—Approved the continuation of the use of IBM in compiling the FMA annual Directory, and authorized the discontinuance of Roster 2, which contained the listing of the Florida State Board of Medical Examiners.

Future Annual Meetings.—Selected the Americana Hotel, Bal Harbour, for the annual meeting, May 5-9, 1971, and the Diplomat Hotel, Hollywood, for the annual meeting, May 3-7, 1972.

Meeting Dates.—Approved the following meeting dates:

January 14, 1967—Saturday—Executive Committee Meeting

January 15, 1967—Sunday, Board of Governors' Meeting

January 28-29, 1967, Saturday and Sunday—Conference of Presidents and Secretaries, Orlando

April 1, 1967—Saturday—Executive Committee Meeting

April 2, 1967—Sunday—Board of Governors' Meeting

July 8, 1967—Saturday—Executive Committee Meeting

September 27-October 1, 1967—Board of Governors' Meeting

Specialty Groups.—Granted official recognition to the Florida Society of Ophthalmology and Florida Society of Otolaryngology and Maxillofacial Surgery, which replaced the Florida Society of Ophthalmology and Otolaryngology; approved the change in name of the Florida Health Officers Society to the Florida Society of Preventive Medicine; and placed the Florida Psychiatric Society's official recognition on probation as a result of this society's going directly to state officials without coordinating through the FMA.

Indigent Care Policy.—Clarified the Association's policy on indigent care to state that when an individual becomes a ward of the government he is no longer considered an indigent patient under the policy of the FMA.

Practice of Medicine.—Requested the Board of Directors of Blue Shield of Florida, Inc., to do everything in its power to maintain the position of pathologists, radiologists, and other physicians as independent practitioners of medicine.

Medicare.—Approved the FMA and the county medical societies establishing or utilizing present committees to handle unusual or protested claims arising from the administration of Title XVIII-B, as requested by Blue Shield of Florida, Inc.

Requested the Board of Directors of Blue Shield of Florida, Inc., to advise the Florida Medical Association of any changes in their determination of usual and customary fees, par-

ticularly those demanded by the federal government, in administering Public Law 89-97, Title XVIII-B.

Fee Activities.—Authorized the revision and updating of the 1962 Florida Medical Association Relative Value Studies at the earliest possible date.

Requested Blue Shield of Florida, Inc., to compile and release to the FMA the data regarding prevailing fee studies and to assist the Association with statistical and IBM service to accomplish the updating of the Relative Value Studies.

Determined that the use of relative value studies by the various specialty groups should in no way bear FMA acceptance or endorsement.

Recommended to the House of Delegates that the By-Laws be amended to change the name of the Fee Schedule Committee to the Committee on Relative Value Studies.

Recommended to the House of Delegates an amendment to abolish the Committee on Dependents Medical Care.

Granted permission to the Florida Society of Anesthesiologists to use part of the Florida Medical Association 1962 Relative Value Studies, providing copyright credit is given.

Requested the Council on Specialty Medicine to review all recommendations regarding the relative values from all specialty groups and after due deliberations make recommendations to the Fee Schedule Committee and reaffirm the Association's previous position that there will be no dual fee schedule or dual Relative Value Studies.

Workmen's Compensation.—Requested that a Florida Medical Association Committee designated by the President discuss and advise the indicated changes in the billing procedures, the relative value studies and the conversion factor regarding care of Workmen's Compensation patients and that the Florida Medical Association be prepared to take necessary legal action to test the validity of the Florida Industrial Commission's interpretation of the Florida Workmen's Compensation statutes in its refusal to pay the usual and customary fees charged by doctors of medicine of Florida for the care of patients with industrial injuries.

FLAMPAC.—Approved the District Chairmen of FLAMPAC as recommended by its President.

FMA Investment Plan.—Approved amend-

ments to the FMA Investment Plan which gives additional responsibility to Loomis-Sayles Investment Counsel and Pan American Life Insurance Company, and reduces the duties of the First Bank and Trust Company to that of a Plan Agent, which will decrease the cost of administration to the individual participants.

Medical Practice Act.—Authorized an FMA conference with the Judicial Council, State Board of Medical Examiners, county medical society representatives, Council on Legislation and Public Agencies, to consider revision of the Medical Practice Act.

History of Florida Medicine Museum.—Implemented Resolution 66-15 on the History of Florida Medicine Museum by utilizing the Committee on Archives, Chairman of the Judicial Council, and three representatives of the St. Johns County Medical Society to pursue the project.

Direct Billing.—Determined that the present form in use by the federal government, SSA-1470, could be used for direct billing by striking the words "I accept assignment," or the individual physician's own billing could be acceptable.

General Practice.—Implemented Resolution 66-24 dealing with general practice by the appointment of an ad hoc committee to carry out the intent of the resolution.

Heart Disease, Cancer and Stroke.—Approved the recommendations of the Florida Advisory Council on Heart Disease, Cancer and Stroke, Inc., in requesting a planning grant to consider the state of Florida as a whole for planning purposes.

Constitutional Revision.—Requested the Association's Council on Legislation and Public Agencies to work toward maintaining the Florida State Board of Health in the proposed new Florida Constitution and maintaining the integrity of the Florida State Board of Medical Examiners.

Other Reports.—Reviewed numerous reports of councils and committees and took appropriate action where necessary. Among these were:

Medical Education and Hospitals.—Approved the Council on Medical Education and Hospitals sponsoring a conference in cooperation with the FMA Committee on Postgraduate Education and the directors of medical education of hospitals, medical school representatives and the appropriate councils and committees of the Association in early December to consider the organization of

directors of medical education as a group, the relationship of hospitals and training programs to the medical schools, relationship of hospitals and training programs to surrounding hospitals, problems of motivation of practitioners, quality of practitioners produced by our programs, and

training of more general practitioners.

Legislation.—Approved the report of the Council on Legislation and Public Agencies outlining the Association's state program for the 1967 session of the Florida Legislature.

Council and Committee Meetings

Editor's Note: The following are summaries of recent council and committee meetings. Final determinations on all actions or recommendations are made by the Association's House of Delegates at the Annual Meeting.

T.M.

Council on Legislation and Public Agencies met August 6 and recommended inclusion of the following legislative measures in the FMA 1967 state legislative program: revision of present abortion law to permit therapeutic abortion for specified reasons; authorization for a modern medico-legal examiners system for the state of Florida; mandatory use of protective helmets and crash bars on motorscooters, motorcycles and motorbikes, and providing for consent for autopsies.

Committee on Postgraduate Education met August 7. A motion carried to send a questionnaire to county medical societies in Florida inquiring into their postgraduate educational needs. The results will be used to guide the committee's future activities.

School Health Medical Advisory Committee met June 5 with the State Superintendent of Public Instruction and his staff. The committee decided to accept a revised school physical examination form and put it into effect at the earliest possible time. The committee voted to write a letter of endorsement for the regional physical fitness cultural centers planning grant proposal of the State Department of Education. It was also agreed that the committee will notify the Board of Governors that the State Department of Education is aware of the discrepancy in the state law which requires a physician to sign a certification for examination for a teachers certificate, and that an appropriate change of this law will be undertaken along with a complete revision of all laws affecting school health.

Committee on Scientific Work met June 12 and again on September 11 to develop the scientific program for the 93rd Annual Meeting, May 10-14, Americana Hotel, Bal Harbour.

Committee on Mental Health met September 18. A decision was made to initiate a statewide survey in cooperation with the Florida Association for Mental Health, the Florida Sheriffs Association and possibly the Florida County Judges Association, to determine the extent of the problem of detention of the mentally ill in jails. The committee also decided to write an official letter to the Florida Association for Mental Health requesting assistance in preparation of a directory or guide for physicians relating to mental health facilities, laws and services. The 1966 conference of key state mental health leaders was scheduled for November 13, FMA building. The committee will re-examine its program of visitations to state institutions and discuss this matter during the state mental health leaders conference.

Committee on Health Insurance met September 18 and recommended to the Board of Governors that the purpose and goals of the committee be re-stated in order that the functions and activities of both the state committee and the county medical society insurance review committees be made more effective and better understood. The committee also recommended procedures to improve and expedite processing of claims submitted for review.

Council on Medical Services met September 10 and reviewed past and present activities of each of its 13 committees. Future programs were planned and coordinated. In view of the increasing

health care rendered in nursing homes, the council recommended that responsibility for liaison with nursing homes and other extended care facilities be placed under the Council on Medical Education and Hospitals with the suggestion that such institutional activities be assigned to the Committee on Hospitals or to a new committee on extended care facilities. Although this responsibility to date has been carried out by the Committee on Aging, it was the council's opinion that

the committee's role should be primarily oriented toward the area of geriatrics. The Committee on Hearing was requested to study the problem of care of indigent hard of hearing children and report findings back to the council. The Committee on Vision was requested to study the possible reorganization and reactivation of the Florida Coordinating Council for Prevention of Blindness and report recommendations back to the council.



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Precautions: Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

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WARNINGS: Use with caution in the presence of renal disease as azotemia may be precipitated or increased. In patients with advanced hepatic disease, electrolyte imbalance may result in hepatic coma. Dosage of coadministered antihypertensive agents should be reduced by at least 50%. In cases of suspected electrolyte imbalance, serum electrolyte determinations should be performed and imbalance, if any, corrected. Stenosis or ulcer of small intestine have been reported with coated potassium formulas, and surgery has been required and deaths have occurred. Based on surveys of both United States and foreign physicians, incidence of these lesions is low and a causal relationship in man has not been definitely established. Until further experience has been obtained, the use of the drug in pregnant patients should be weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or dysfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties. Severe hepatic disease is a relative contraindication. (See "Warnings" above)

PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia (digitalis toxicity may be precipitated), hypochloremic alkalosis and hyponatremia may occur. Patients with cirrhosis should be observed for impending hepatic coma and hypokalemia. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Hepatic fever, tremor, confusion and drowsiness are signs of impending pre-coma and coma in patients with cirrhosis. Insulin requirements may be altered in diabetes. AQUATAG (benzthiazide) should be used with caution post-operatively as hypokalemia is not uncommon. Potassium supplementation may be advisable pre- and post-operatively. There have been occasional reports of thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia and precipitation of acute pancreatitis or jaundice.

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Meetings

November

- 7-11 "Interpretation of Cardiac Arrhythmias," Mount Sinai Hospital, Miami Beach.
- 10-12 Pediatric Seminar, University of Florida, Gainesville.
- 17-18 Obstetrics and Gynecology Seminar, University of Florida, Gainesville.
- 17-19 "Pediatric Neurology," Florida Pediatric Society Fall Meeting, Beach Club Hotel, Ft. Lauderdale.

December

- 1-3 "The Lower Extremity Amputee—Surgery and Prosthetic Management," University of Miami, Americana Hotel, Miami Beach.
- 1-4 Fourth Annual Cardiology Seminar, Rogers Heart Foundation, Tides Bath Club, St. Petersburg.

January

- 2-6 Neuro-Ophthalmology Symposium, Bascom Palmer Eye Institute, Americana Hotel, Bal Harbour.
- 5-7 Postgraduate Seminar in Surgery, University of Miami Department of Surgery and FMA, Fontainebleau Hotel, Miami Beach.
- 13-14 Birth Defects Seminar, National Foundation and Jacksonville Hospitals Educational Program, St. Vincents Hospital, Jacksonville.
- 13-15 "Current Concepts in Treatment and Diagnosis of Central Nervous System Neoplasms," University of Miami School of Medicine, Eden Roc Hotel, Miami Beach.
- 15-20 "Acid Base Disorders in Internal Medicine, Surgery and Pediatrics," University of Miami School of Medicine, Fontainebleau Hotel, Miami Beach.

February

- 8-17 Psychiatry in Medical Practice, Advanced Course, University of Miami School of Medicine, Jackson Memorial Hospital, Coral Gables.
- 8-17 Psychiatry in Medical Practice, Basic Course, University of Miami School of Medicine, Jackson Memorial Hospital, Coral Gables.

March

- 17 Psychiatry Seminar, University of Florida College of Medicine, Gainesville.

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The complete scientific program, plus forms for advance registration and hotel accommodations, will be featured in JAMA October 24.

Books

Medical Pharmacology. Principles and Concepts. Andres Goth, M.D. Ed. 3. Pp. 668. Illustrated. \$12.50. St. Louis, The C. V. Mosby Company, 1966.

Neurology of the Visual System. By David H. Hubel, M.D. Pp. 413. Illustrated. Price \$14.50. Springfield, Ill., Charles C. Thomas Publisher, 1965.

Caring for the Aged. By Bertram B. Moss, M.D. Pp. 372. Price \$4.95. Garden City, N.Y., Doubleday Company, Inc., 1966.

The Medical Department: Medical Service in the Mediterranean and Minor Theaters, The Technical Services, United States Army in World War II. By M. Wiltse. Pp. 664. Illustrated. Price \$5.00. Office of the Chief of Military History, Department of the Army, Washington, D. C., 1965.

Blood Diseases of Infancy and Childhood. By H. Smith, M.A., M.D. Ed. 2. Pp. 800. Illustrated. \$22.00. St. Louis, The C. V. Mosby Company, 1966.

Symposium on Surgery of the Ocular Adhesions. By the New Orleans Academy of Ophthalmology. Pp. 245. Illustrated. Price \$16.00. St. Louis, The C. V. Mosby Company, 1966.

Pathology. Edited by W. A. D. Anderson, M.A., F.A.C.P., F.C.A.P. Ed. 5. Vol. 1, Pp. 767-1439. Vol. 2, 767-1439. Illus. 1260. Price \$21.00. St. Louis, The C. V. Mosby Company, 1966.

Resuscitation of the Newborn Infant. Edited by Harold Abramson, A.M., M.D. Ed. 2. Pp. 412. Illustrated. Price \$16.50. St. Louis, The C. V. Mosby Company, 1966.

The Pediatrician's Ophthalmology. Edited by D. Lieberman, M.D. and Sydney S. Gellis, M.D. Pp. 352. 120 illus. Price \$19.50. St. Louis, The C. V. Mosby Company, 1966.

Synopsis of Neurology. Francis M. Forster, M.D. Ed. 2. Pp. 218. Price \$7.50. St. Louis, The C. V. Mosby Company, 1966.

Encyclopedia for Medical Assistants. Edited by Louis Brachman, M.D. Pp. 448. Illustrated. Milwaukee, Wisconsin, Cathedral Square Publishing Company, 1966.



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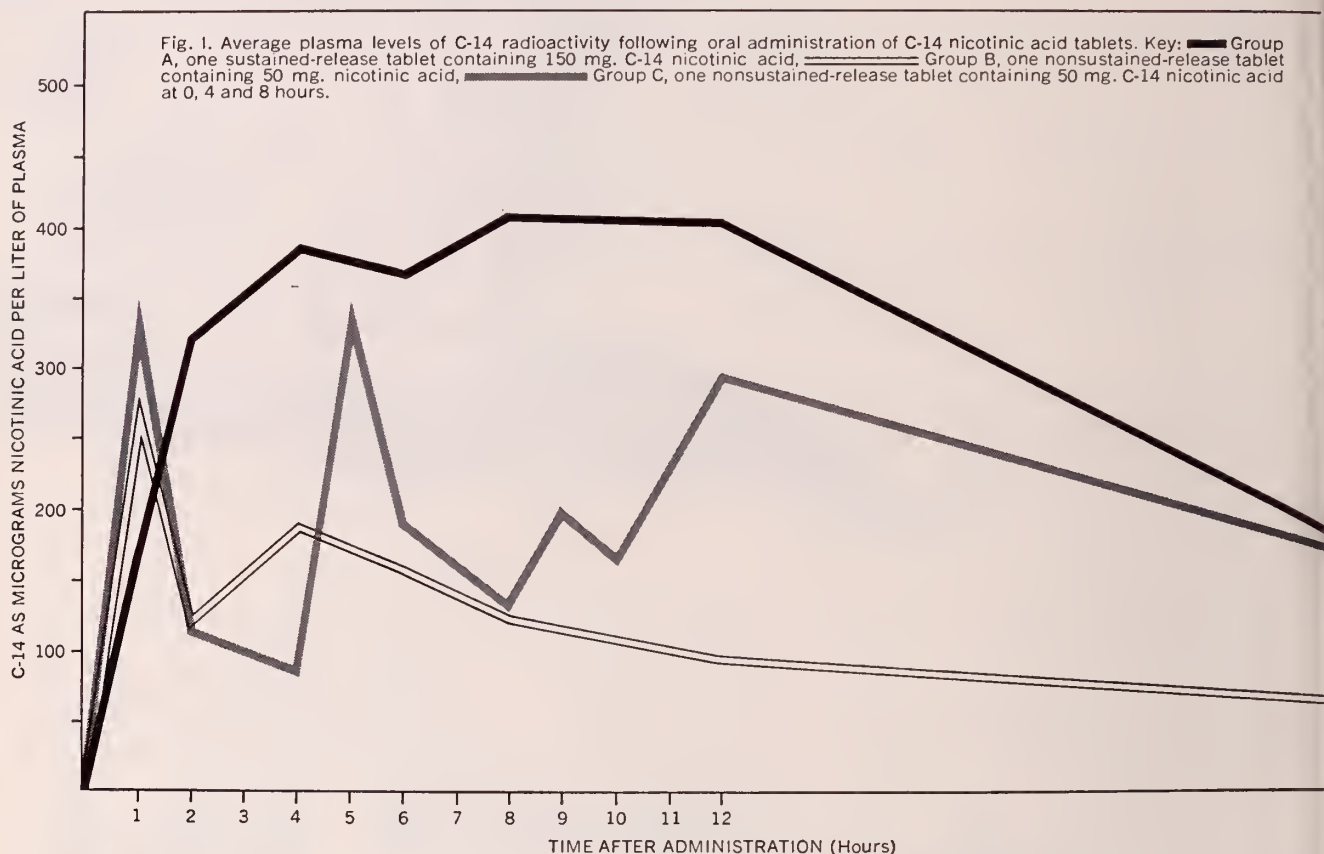


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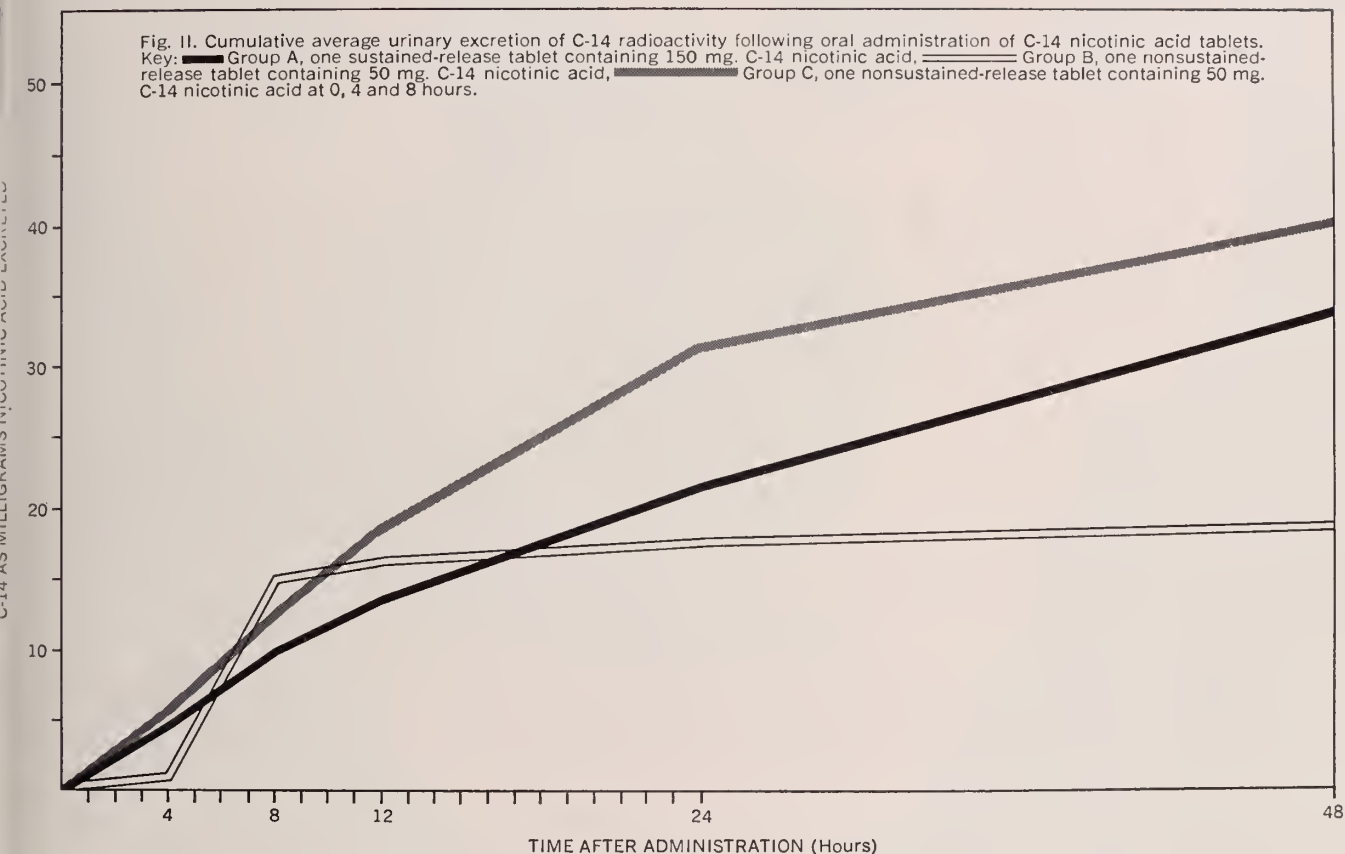
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Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. 56:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. 11:617 (July) 1960.



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Later, other investigators showed by dog experiments that metabolic acidosis probably resulted when the inhibition of carbonic anhydrase upset the exchange of hydrogen and sodium ions, causing increased excretion of sodium as the bicarbonate.³

It was twelve long years after the first report of the unexplainable side effect (metabolic acidosis) that it was finally shown that large doses of sulfanilamide administered to edematous patients were indeed capable of promoting diuresis.⁴ However, the possibility of toxic effects from its prolonged use and its relatively weak diuretic action made it impractical for clinical use as a diuretic.⁵

Because the inhibition of carbonic anhydrase seemed to be the key to effective diuresis, investigators began to look for more potent enzyme inhibitors—in the hopes that they would be more effective diuretics.

The most important of these early compounds, acetazolamide, enjoyed several years of fairly wide clinical use.

Its carbonic anhydrase inhibitory activity was several hundred times greater than that of sulfanilamide.⁶ The increase in inhibitory activity, however, increased not only the excretion of sodium and bicarbonate ions, but also the excretion of potassium.⁷ And, like its predecessor, acetazolamide precipitated mild acidosis. Its prolonged use could result in hypokalemic acidosis.⁷

The 'thiazides'—an answer to the metabolic acidosis caused by carbonic anhydrase inhibition

Despite the fact that the sulfonamide

group appeared to be responsible for carbonic anhydrase inhibition which in turn appeared to be responsible for diuresis, investigators began to synthesize compounds with structural alterations to the sulfonamide group.

The first major breakthrough came with the synthesis of chlorothiazide. Altering the sulfonamide group did indeed alter the ability of chlorothiazide to inhibit carbonic anhydrase—it was only 1/10th as potent as acetazolamide in inhibiting the enzyme.⁸ Despite the drop in inhibitory potency, however, chlorothiazide proved to be an effective diuretic—an observation that led to the conclusion that its diuretic action was due to some mechanism other than its action on carbonic anhydrase.^{9,10}

For effective diuresis, chlorothiazide was administered in daily dosages ranging from 250 to 2000 mg.¹¹ It increased the excretion of sodium and chloride; and, to a lesser extent, potassium and bicarbonate.¹¹ The excretion of potassium appeared to be maximal at higher dose levels at which, theoretically, the carbonic anhydrase inhibitory effect is more active.¹¹ Its prolonged use, therefore, could sometimes result in metabolic hypokalemic, hypochloremic alkalosis.⁷

Naturetin—effective diuresis with more favorable electrolyte balance

Other thiazides followed—with improvements being aimed at two particular areas: 1. attempts to increase diuretic action in relation to the milligram potency of the drug, and 2. attempts at a more favorable sodium/potassium ratio in the urine, i.e., to decrease the excretion of potassium while maintaining the excretion of sodium.¹²

One of these, Naturetin, Squibb Bendroflumethiazide, has made advances on both these points. "By adding a 3-benzyl radical to hydroflumethiazide a rather dramatic reduction in dose range is accomplished. With this drug, effective sodium excretion is obtained with

doses between 2.5 and 10 mg., which is a 200 to 1 ratio as compared to chlorothiazide..."¹³

Moreover, due probably to its virtual lack of carbonic anhydrase inhibition, Naturetin (bendroflumethiazide) has been shown to cause less potassium and bicarbonate loss and less alteration in urinary pH than either chlorothiazide or hydrochlorothiazide.

Naturetin is outstandingly effective not only in establishing, but also in maintaining, excretion of retained fluid in edematous patients. And its duration of action is sufficiently prolonged to allow a single daily administration in most patients. Naturetin is also an effective antihypertensive agent.

Contraindications: Severe renal impairment; previous hypersensitivity.

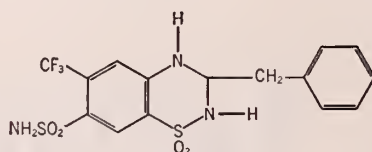
Warning: Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting, or G.I. bleeding occur.

Precautions: The dosage of ganglionic blocking agents, veratrum, or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Electrolyte disturbances are possible in cirrhotic or digitalized patients.

Side Effects: Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, and rashes may occur.

Supplied: Naturetin (Squibb Bendroflumethiazide) 5 mg. and 2.5 mg. tablets. Also available Naturetin \bar{c} K [Squibb Bendroflumethiazide (5 or 2.5 mg.) with Potassium Chloride (500 mg.)]. For full information, see Product Brief.

References: 1. Southworth, H.: *Proc. Soc. Exper. Biol. & Med.* 36:58, 1937. 2. Mann, T. and Keilin, D.: *Nature* 146:164, 1940. 3. Pitts, R. F., and Alexander, R. S.: *Am. J. Physiol.* 144:239, 1945. 4. Schwartz, W. B.: *New England J. Med.* 240:173, 1949. 5. Friedberg, C. K., in Moyer, J. H., and Fuchs, M.: *Edema Mechanisms and Management*, Philadelphia, W. B. Saunders Co., 1960, p. 259. 6. Cumming, J. R.; Tabachnick, E., and Seelig, M., in Moyer, J. H., and Fuchs, M.: *op. cit.*, p. 254. 7. Werko, L., in Moyer, J. H., and Fuchs, M.: *op. cit.*, p. 188. 8. Beyer, K. H., Jr., in Moyer, J. H., and Fuchs, M.: *op. cit.*, p. 274. 9. Maren, T. H., and Wiley, C. E.: *J. Pharmacol. & Exper. Therap.* 143:230, 1964. 10. Earley, L. E., and Orloff, J.: *Ann. Rev. Med.* 15:149, 1964. 11. Fuchs, M., and Mallin, S. R., in Moyer, J. H., and Fuchs, M.: *op. cit.*, p. 276. 12. Ford, R. V., in Moyer, J. H., and Fuchs, M.: *op. cit.*, p. 290. 13. cited in Fuchs, M., and Mallin, S. R. (ref. 11): *op. cit.*, p. 283.




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Dimetapp® Extentabs®

(Dimetane® [brompheniramine maleate], 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)

In sinusitis, colds, or U.R.I., Dimetapp lets congested patients breathe easy again. Each Extentab brings welcome relief all day or all night, usually without drowsiness or overstimulation. Its key to success? The Dimetapp formula — Dimetane (brompheniramine maleate), a potent antihistamine reported in one study to have elicited side effects as few as the placebo,* teamed with decongestants phenylephrine and phenylpropanolamine — in a dependable 10- to 12-hour form.

Contraindications: Patients hypersensitive to antihistamines. Not recommended for use during pregnancy.

Precautions: Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.

Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia have been reported on

rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability, or excitement may be encountered.

Dosage: 1 Extentab morning and evening, or as needed.

Supplied: Bottles of 100 and 500.

Also available: Dimetapp® Elixir for conventional *t.i.d.* or *q.i.d.* dosage. See package insert for further details.

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*Schiller, I. W., and Lowell, F. C.: New England J. Med. 261:478, 1959.

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(Warning: may be habit forming)

Contraindications: Hypersensitivity to any ingredient.

Precautions: As with all phenacetin-containing products, avoid excessive or prolonged use.

Side Effects: Side effects are uncommon—nausea, constipation, and drowsiness have been reported.

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Gebauer's Ethyl Chloride stops creeping eruption cold



highly magnified drawing of the *Ancylostoma Braziliense*

Creeping eruption is ugly, uncomfortable, and persistent. And, in Florida, it is seen with considerable frequency.

Creeping eruption is caused by the larvae of the dog and cat hookworm, *Ancylostoma Braziliense*. The larvae of this parasite burrow between the superficial layers of the skin, causing much discomfort and characteristic angry eruptions.

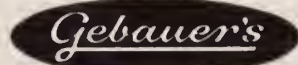
Happily, Gebauer Ethyl Chloride sprayed on the affected area for 30 seconds to one minute will usually kill the offending larvae. In difficult cases, it may be necessary to spray for a period of up to two minutes. Improvement and cure generally follow a comparatively few applications.

Next time you treat creeping eruption, treat it with Gebauer Ethyl Chloride. Also highly effective as a topical anesthetic for minor surgery, as in removal of splinters, incision of boils and whitlows, and to alleviate needle pain. May be used for relief of pain such as first and second degree burns, bee stings, sprains and muscle spasm.

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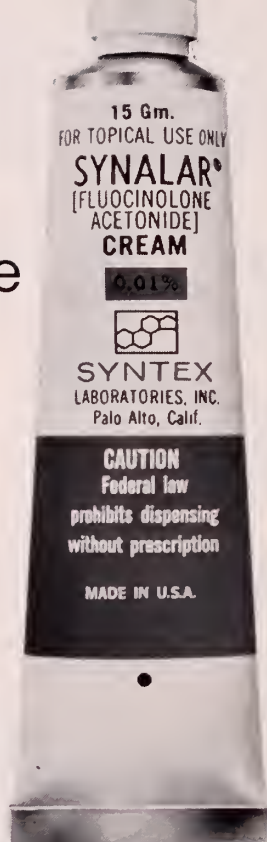
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Now you can prescribe as little or as much Synalar Cream 0.01% as is needed for a particular therapeutic problem in a size that permits the greatest economy for your patient. The new 15 Gm. tube, for example, is best suited for short-term therapy and for small sites. For more extensive body areas prescribe the 45 Gm. tube—a size that's also ideal for your treatment table. And the 120 Gm. jar is most economical for hospital use. Thus, with Synalar Cream 0.01%, you have the superiority of a modern topical corticosteroid shown to be more effective than 1% hydrocortisone¹⁻³ plus the economy that makes therapy practical for use in more dermatologic conditions, in long-term maintenance, with occlusive dressings in resistant cases, and in extensive area involvement.

Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of its components. **Precautions:** 1. *General*—Synalar Cream 0.01% is virtually nonsensitizing and nonirritating. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to

have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. 2. *Occlusive dressing method*—With occlusion of extensive areas, systemic absorption of the corticosteroid may occur, and special precautions should be taken. Occasional patients may show contact sensitivity to a particular dressing material or adhesive. Miliaria, folliculitis, pyoderma have been seen infrequently with the use of this technique. Development of infection requires appropriate antibacterial therapy. Continuation of the occlusive dressing method. Local atrophy and telangiectases have been reported with protracted occlusive dressing therapy. While relapses can be expected to occur in many psoriatic patients, remissions may persist for several weeks to several months in favorable cases. Patient whose psoriasis is in an active stage, with recent appearance of lesions, may not be a good candidate and may show early relapse. Plastic films may be flammable, and due care should be exercised in their use. Similarly, caution should be employed when such films are used on the left near children to avoid the possibility of accidental suffocation. **Effects:** Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. **References:** 1. Cahn, M. Levy, E. J.: *J New Drugs* 1:262 (Nov.-Dec.) 1961. 2. Meenan, F. O.: *Med Ass* 52:75 (Mar.) 1963. 3. Robinson, H. M., Jr., Raskin, J., and Deane, W. J. R.: *Southern Med J* 56:797 (Jul.) 1963.

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NEWS

FMA Member Honored By Tampa Times

Dr. W. M. Rowlett, Tampa obstetrician and gynecologist and 1933 FMA President was honored in an August 20 Tampa Times news feature.

The news feature, entitled "A Tampa Portrait," highlighted many of the outstanding accomplishments in Dr. Rowlett's diversified career as a student, sportsman and physician.

For example, Dr. Rowlett was captain of the first University of Florida football team in 1905; medical student at Emory University, completing four years in three by 1909; the first specialist in obstetrics and gynecology in Tampa; secretary of the regular board of medical examiners six months after he opened practice, and the only chairman of the parks board the city of Tampa has ever had, having served continuously in this position since his election in 1920.

FMA Member Elected To National Board

Dr. Sanford A. Mullen, Jacksonville pathologist and FMA member, has been elected to the 12-member board of governors of the College of American Pathologists.

Dr. Mullen was named to a three year term on the national board at an annual business meeting held in Washington,

D. C. The board members were elected from the organizations nationwide membership of approximately 4,500.

Dr. Mullen is presently chairman of the FMA Committee on Pathology and is also a member of the FMA Committee on Medical Technologists. He has practiced in Jacksonville for 10 years.

Accidental Ingestion Of Harmful Substances

One fourth of all cases involving accidental ingestion of harmful substances by children under five were due to the swallowing of aspirin, according to reports sent to the National Clearinghouse for Poison Control Centers last year.

The Clearinghouse, a branch of the Public Health Service's Division of Accident Prevention, collects and disseminates information on prevention and treatment of accidental poisonings to more than 550 poison control centers.

Dr. Paul Joliet, chief of the division, said that a survey by the Clearinghouse showed that harmful ingestions, after aspirin, by children under five most frequently involved soaps, detergents and cleaners, bleach, vitamins and minerals, insecticides, plants, polishes and waxes, hormones (including oral contraceptives and thyroid tablets), tranquilizers and other analgesics and antipyretics.

FBS Appoints New Executive

The Florida Blue Shield Board of Directors has appointed W. Joe Stansell of Jacksonville to the newly established position of assistant to the executive director for Blue Shield.

Stansell, formerly manager of the Blue Shield Physician Relations Department and associated with Blue Shield of Florida since 1953, will devote full time to Blue Shield activities.

AMA Lecture Held in Lakeland

Dr. R. H. Kampmeier, professor of medicine emeritus, department of biochemistry, Vanderbilt University School of Medicine, was the featured speaker at the American Medical Association Lecture in Clinical Nutrition given at Florida Southern College, Lakeland, October 11.

Dr. Kampmeier is a graduate of the State University of Iowa College of Medicine, and has served as assistant professor at Louisiana State University School of Medicine and visiting physician at Charity Hospital. Joining the staff of Vanderbilt University School of Medicine as assistant professor of medicine, he became professor of medicine, and reached emeritus status in 1963. He is currently director of continuing education there.

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CANTIL[®] (mepenzolate bromide)

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"In 40 of 44 cases of irritable or spastic colon, Cantil [mepenzolate bromide] or Cantil with Phenobarbital reduced or abolished abdominal pain, diarrhea and distention and promoted restoration of normal bowel function . . . Cantil [mepenzolate bromide] proved to be singularly free of anticholinergic side-effects . . . Urinary retention, noted in two cases was eliminated in one by reducing dosage."¹

IN BRIEF: One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withdraw in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

Supplied: CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

¹. Riese, J. A.: Amer. J. Gastroent., 28:541 (Nov.) 1957

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Behind continued high blood pressure readings lies the possibility of organic damage¹⁻¹³

MANY OF THE aspects of essential hypertension are unpredictable—either because there are a number of mechanisms involved or because individuals differ in their responses to these mechanisms.¹

There is one aspect of hypertension, however, that seems, in many cases, predictable. "... when the blood pressure is elevated to a marked degree for an adequate period of time, this in itself leads to perpetuation of the syndrome with resulting vascular damage throughout the body."¹⁴ All too often the disease progresses until there is damage to one of three vital organs: the heart, the kidney, the brain.



"Hypertension is certainly a major factor in the genesis of coronary heart disease, and it is even more important when compounded with obesity."⁴

"[Vascular deterioration] can be clearly seen in the kidney with a degree of damage that can be measured by renal function studies."¹⁰

"... most evidence suggests that reduction of blood pressure, when it is too high, not only relieves the heart of excess work but reduces vascular damage."¹

"In short, treatment is indicated."¹

Antihypertensive therapy will not restore the blood vessels to normal. Yet many of the vascular changes and symptoms caused by increased blood pressure may be arrested or alleviated when the blood pressure is reduced to normotensive levels.⁷

Reducing the blood pressure helps curtail further vascular damage and improves the prognosis — when damage is not too far advanced before therapy is started.¹⁴ Essential hypertension is an indication not only for treatment, but for early and adequate treatment of the patient in question.

Reduce the blood pressure with Rautrax-N

Rautrax-N combines the antihypertensive-tranquilizing action of whole root rauwolfia with the antihypertensive-diuretic action of bendroflumethiazide in one convenient medication. The two drugs complement each other

so that smaller doses of both are possible.

Rauwolfia combined with bendroflumethiazide is particularly effective in long-term therapy,¹⁵⁻¹⁷ since beneficial effects do not diminish with continuous daily administration.

For most patients 1 or 2 Rautrax-N tablets daily are sufficient for maintenance therapy. The simplicity, convenience and economy of such a dosage schedule are of particular benefit to older patients.

References: 1. Page, I. H., and Dustan, H. P.: The Usefulness of Drugs in the Treatment of Hypertension, in Ingelfinger, F. J.; Relman, A. S., and Finland, M.: Controversy in Internal Medicine, Philadelphia, W. B. Saunders Co., 1966, p. 95. 2. Hollander, W.: The Evaluation of Antihypertensive Therapy of Essential Hypertension in Ingelfinger, F. J.; Relman, A. S., and Finland, M.: Controversy in Internal Medicine, Philadelphia, W. B. Saunders Co., 1966, p. 97. 3. Nickerson, M.: Antihypertensive Agents and the Drug Therapy of Hypertension, in Goodman, L. S., and Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 3, New York, The Macmillan Co., 1965, p. 727. 4. Berkson, D. M.: Indust. Med. & Surg. 32:371, 1963. 5. Cohen, B. M.: M. Times 91:645, 1963. 6. Lee, R. E., et al.: Am. J. Cardiol. 11:738, 1963. 7. Moyer, J. H.: Am. J. Cardiol. 9:821, 1962. 8. Moser, M.: New York J. Med. 62:1177, 1962. 9. Wood, J. E., and Battley, L. L.: Am. J. Cardiol. 9:675, 1962. 10. Moyer, J. H., and Heider, C.: Am. J. Cardiol. 9:920, 1962. 11. Moser, M., and Macaulay, A. I.: New York State J. Med. 60:2679, 1960. 12. Judson, W. E.: Nebraska M. J. 44:305, 1959. 13. Hodge, J. V.; McQueen, E. G., and Smirk, H.: Brit. M. J. 1:5218, 1961. 14. Moyer, J. H., and Brest, A. N.: Hypertension Recent Advances, Philadelphia, Lea & Febiger, 1961, p. 633. 15. Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. 10:516, 1962. 16. Reid, W. J.: J. Am. Geriatrics Soc. 13:365, 1965. 17. Feldman, L. H.: North Carolina M. J. 23:248, 1962.

Contraindications: Severe renal impairment or previous hypersensitivity. **Warning:** Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distention, nausea, vomiting or G.I. bleeding occur.

Precautions and Side Effects: The dose of ganglionic blocking agents, veratrum or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Caution is indicated in patients with depression, suicidal tendencies, peptic ulcer; electrolyte disturbances are possible in cirrhotic or digitalized patients. Marked hypotension during surgery is possible; consider discontinuing two weeks prior to elective surgery and observe patients closely during emergency surgery. Rauwolfia preparations may cause reversible extrapyramidal symptoms and emotional depression, diarrhea, weight gain, edema, drowsiness may occur. Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients, and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, rashes may occur.

Dosage and Supply: Initial dosage, 1 to 4 tablets daily, preferably at meal-time. Maintenance, 1 or 2 tablets daily. Rautrax-N is supplied as capsule-shaped tablets containing 50 mg. Rauwolfia serpentina whole root (Raudixin®), 4 mg. bendroflumethiazide (Naturetin®), 400 mg. potassium chloride.

Also available: Rautrax-N Modified — capsule-shaped tablets containing 50 mg. Rauwolfia serpentina whole root (Raudixin), 2 mg. bendroflumethiazide (Naturetin), 400 mg. potassium chloride. Both potencies available in bottles of 100. For full information, see Product Brief.

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Standardized cellulolytic* enzyme, 2 mg.;
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Pancreatin 3X** (source of lipolytic activity),
100 mg.; Taurocholic acid, 15 mg.

*Need in human nutrition not established.

**As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.

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In chronic or acute indigestion, fluttery, gassy stomachs obtain prompt, gratifying relief through the antispasmodic, surface anesthetic and enzymatic activity of Dactilase. Dactilase decreases hypermotility and pain and reduces the production of gas. Dactilase does not induce stasis, but helps restore normal tone. It has little or no effect on enzyme secretions, but *adds* enzymes, thus contributing to the digestive efficiency of the patient.

Side Effects and Contraindications:

Dactilase is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

Administration and Dosage: One tablet with, or immediately following, each meal. Tablets should be swallowed whole.

Supplied: Bottles of 60 and 250.

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However, tolerance to
develops without loss of
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sage should not

Occasional lightheadedness
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a coronary vasodilator.

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Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive.

Contraindication—History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort.

Precautions and Side Effects—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

Capsules: 150 mg; *Tablets:* film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.



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FOR COLD
HANDS AND FEET**



For cold hands and feet, nothing beats hot stoves—but they *are* awkward to carry around. Now Gerilid, in good-tasting take-along chewable tablets can provide rapid vasodilation of peripheral circulation, bringing real warmth to the extremities and decreasing sensitivity to sudden temperature change. Patients *like* Gerilid and *know* they are getting relief.

GERILID™

Each chewable tablet contains:
nicotinic acid (niacin) 75 mg. and
aminoacetic acid (glycine) 750 mg.

Administration and Dosage: One or two chewable tablets 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation. The recommended dosage should not be exceeded.

Side effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is a concomitant administration of a coronary vasodilator.

Supplied: Packages of 50 chewable tablets.

Also available in liquid form as Geriliquid®, in bottles of 8 and 16 ounces.

LAKE SIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201



PRODUCTS
FOR PATIENTS
YOU SEE
EVERY DAY



The comfortable way to get well...™

When headache, fever, pain,
malaise accompany bacterial URI

Tetrex[®]-APC WITH BRISTAMIN[®]

(tetracycline phosphate complex with analgesics and antihistamine)

With a single prescription, you can add all the known benefits of Tetrex (tetracycline phosphate complex) to the traditional relief provided by APC. At the same time Bristamin (phenyltoloxamine citrate), provides relief of allergic symptoms—watery eyes, rhinorrhea and congestion.

BRISTOL THERAPEUTIC SUMMARY. For complete information, consult Official Package Circular. **Indications:** Upper respiratory infections due to sensitive bacteria where concomitant symptomatic relief of fever, malaise and congestion is desired. **Contraindication:** A past history of hypersensitivity to one or more components. **Warnings:** Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Teeth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). **Precautions:** Antihistamines may cause drowsiness and patients should not perform tasks

requiring mental alertness while taking this agent. Bacterial or mycotic superinfection may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for three months. **Adverse Reactions:** Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis and allergic reactions may occur. **Usual Adult Dose:** Two capsules q.i.d. Continue therapy for at least 10 days in beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. **Supplied:** Bottles of 24 and 100.

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York

WHAT'S THE
COMMON
DENOMINATOR? ...IRON



In fact, there's as much iron...250 mg.
...in a 5 cc. ampul of Imferon (iron dextran injection) as in a pint of whole blood.
When iron deficient patients are intolerant of oral iron...or orally administered iron proves ineffective or impractical...or if the patient cannot be relied upon to take oral iron as prescribed, Imferon (iron dextran injection) dependably increases hemoglobin and rapidly replenishes iron reserves.

IMFERON® (iron dextran injection)

IN BRIEF: ACTION AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion as a source of iron; infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb/100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. Initial test doses are advisable. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylatoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

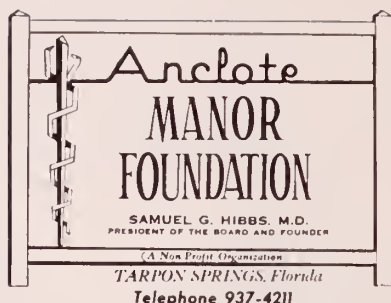
CARCINOGENICITY POTENTIAL: Using relatively massive doses. Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201



PRODUCTS
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Member Notional Association
of Private Psychiatric Hospitals,
Approved by
American Psychiatric Association,
Accredited by Joint Commission
on Accreditation of Hospitals.

A modern hospital offering intensive and comprehensive psychiatric treatment. The completeness of the unification of the entire staff makes the approach unique, but not radical. All acceptable treatment modalities are used but absolute precedence is given to psychotherapy, individual and group, with special attention to the family process.

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Established 1916

NORTH CAROLINA



An Institution for the diagnosis and treatment of Psychiatric and Neurological illnesses, rest, convalescence, drug and alcohol habitation.

Insulin Coma, Electroshock and Psychotherapy are employed. The Institution is equipped with complete laboratory facilities including electroencephalography and X-ray.

Appalachian Hall is located in Asheville, North Carolina, a resort town, which justly claims an all around climate for health and comfort. There are ample facilities for classification of patients, rooms single or en suite.

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**SAVES
LIVES
SAVES
MONEY
WASTES
WATER**



METAHYDRIN (trichlormethiazide) is prescribed by physicians because it not only approximates the diuretic efficacy of parenteral meralluride injection . . . but, *it is the least expensive of all "brand-name" thiazides.* Therefore, when you prescribe METAHYDRIN (trichlormethiazide) your patients receive the thiazide diuretic that removes a little more salt and water than earlier thiazides, with relatively less loss of potassium . . . and, it's therapy they can more easily afford . . . *only pennies a day.*

METAHYDRIN[®] (trichlormethiazide)

oral diuretic

Dosage: One 2 or 4 mg. tablet once or twice daily.

Precautions: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

Side Effects: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have occasionally been noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by the administration of thiazides.

Contraindications: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

How Supplied: Bottles of 100 and 1000 tablets.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201



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Butazolidin[®] alka

phenylbutazone, 100 mg.
dried aluminum hydroxide gel, 100 mg.
magnesium trisilicate, 150 mg.
homatropine methylbromide, 1.25 mg.

The trial period need not exceed 1 week. In contrast, the recommended trial period for indomethacin is at least 1 month.

That's why it's logical to start therapy with Butazolidin alka—you'll know quickly whether or not it works. And usually, it will.

A large number of investigators have reported major improvement in about 75% of cases. Some patients have gone into remission. Relief of stiffness and pain may be followed quickly by improved function and resolution of other signs of inflammation. And Butazolidin alka is well tolerated, especially since it contains antacids and an antispasmodic to minimize gastric upset.

Contraindications

Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should be used with greater care in the elderly and should not be given when the patient is senile or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

Warning

If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time.

Usually works within 3 to 4 days in osteoarthritis

Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Use with caution in the first trimester of pregnancy.

Precautions

Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made to guard against blood dyscrasias.

Adverse Reactions

The most common adverse reactions are nausea, edema and drug rash. Moderately lowered red cell count may sometimes occur due to hemodilution. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vertigo or languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be

attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects.

Confusional states, hyperglycemia, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported. Some patients have hepatitis, jaundice and several cases of anuria and hematuria. With long-term use reversible thyroid hyperplasia may occur infrequently.

Dosage

The initial daily dosage in adults is 300-600 mg. daily in divided doses. In most instances 400 mg. daily is sufficient. When improvement occurs, dosage should be decreased to the minimum effective level: this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

For complete details, please refer to full prescribing information.
6509-V(B)

Also available: Butazolidin[®], phenylbutazone Tablets of 100 mg.



Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York

BU-3804R

Geigy

**BRING IT DOWN
AND
KEEP IT DOWN**

190
102

Metatensin lowers blood pressure and keeps it low—effectively and economically. It combines reserpine with trichlormethiazide which affords more potent saluresis with less loss of potassium than from earlier thiazides. Reserpine contributes antihypertensive effect by relieving anxiety and tension. Metatensin is well-tolerated over long periods; with its effectiveness and economy it assures antihypertensive therapy you and your patients can stay with.

METATENSIN®

Each scored tablet contains:
METAHYDRIN® (trichlormethiazide)
2 mg. or 4 mg. and
Reserpine 0.1 mg.

Usual adult dose: One tablet twice daily. **Precautions and side effects:** Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery.

Contraindications: Complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.

Supplied: Metatensin tablets, 2 mg., 4 mg.—bottles of 100 and 1000.

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RICHMOND, VIRGINIA

A private hospital for diagnosis and treatment of psychiatric and neurological disorders. Hospital and out-patient services.

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Founded in 1904

HIGHLAND HOSPITAL, INC.

ASHEVILLE, NORTH CAROLINA
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Contact: Medical Director, Highland Hospital, Asheville,
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A non-profit, psychiatric institution, offering therapeutic milieu, group and individual psychotherapy, and standard somatic treatments. Limited day-patient and out-patient services. The hospital is located in a 75-acre park amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and emotional rehabilitation.

Doctor,

Here is the Abbott anorectic program designed to meet the individual needs of your overweight patients.



mood elevation

Abbott
Anorectic
Program

DESOXYN® Gradumet® (methamphetamine hydrochloride)

Smooth appetite control plus mood elevation.

The obese patient on a diet often has to battle depression as well as overweight. Desoxyn Gradumet helps the dieter in both battles by elevating the mood while it curbs the appetite. Thanks to the Gradumet, medication is smoothly released all-day from a single oral dose.

If she can't take plain amphetamine, put her on **DESBUTAL® Gradumet**

Calms anxieties; controls compulsive eating.

Desbutal Gradumet provides 2 drugs in 2 tablet sections, combined back to back to form a single tablet. One section contains Desoxyn to curb the appetite and lift the mood; the other contains Nembutal® (pentobarbital) to calm the patient and counteract any excessive stimulation.

Both drugs are released in an effective dosage ratio throughout the day.



controlled release

Abbott
Anorectic
Program

Not all long-release vehicles are the same. Here is why the Gradumet is different and what it means for your overweight patients.



The release action is purely physical and relies on only one factor common to every patient: gastrointestinal fluid. There is no dependence on enteric coatings, enzymes, motility, or an "ideal" ion concentration in the gastrointestinal tract.

Your patients get a measured amount of medication, moment by moment, throughout the day.

They are not subjected to ups and downs of drug release . . . or to erratic release from patient to patient . . . or to erratic release in the same patient from day to day.

That's why the Gradumet provides controlled-release as well as long release.



Perhaps you saw the Gradumet model demonstration which shows that the release is entirely physical. When fluid is added, the drug in the outer ends of the channels dissolves. As fluid penetrates deeper into the channels, there is a continuous release of medication. The rate of release is rigidly controlled by the size and number of channels.

choice of 5 strengths

Abbott
Anorectic
Program

DESOXYN Gradumet

Methamphetamine Hydrochloride in Long-Release Dose Form



5 mg.



10 mg.



15 mg.

DESBUTAL 10 Gradumet

10 mg. Methamphetamine Hydrochloride,
60 mg. Pentobarbital Sodium



Front



Side

DESBUTAL 15 Gradumet

15 mg. Methamphetamine Hydrochloride,
90 mg. Pentobarbital Sodium



Front



Side

samples available



Each sample contains 6 tablets and a filled Sucaryl® Sweetener dispenser. For a supply, write Abbott Laboratories or ask your Abbott man.

Desbutal 15 Gradumet

Product of choice for patients who overreact to plain amphetamine

As an anorectic in treatment of obesity, also to counteract anxiety and mild depression. Desbutal is contraindicated in patients taking a monoamine oxidase inhibitor. Nervousness or excessive sedation have occasionally been observed. Often these effects will disappear after a few days. Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism or who are sensitive to sympathomimetic drugs. Careful supervision is advisable with maladjusted individuals.

A single Gradumet tablet in the morning provides all-day appetite control.

Desbutal 10 contains 10 mg of methamphetamine hydrochloride and 60 mg of pentobarbital sodium. Desbutal 15 contains 15 mg of methamphetamine hydrochloride and 90 mg of pentobarbital sodium. In bottles of 100 and 500.

Sucaryl Sweeteners

A proven aid to weight control—

For use in beverages and foods—stable to heat

A constant reminder to your patient to "watch her calories"

A carefully balanced formula to prevent aftertaste

—in tablets and liquid—

Sucaryl—Abbott brand of low and non-caloric sweeteners

Press out tablets from this side

LOT NO. 784 1331



For:

Directions:

Dr.



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economy

Patients, in many cases, save enough to get five weeks of medication for the price of four, compared to other leading long-release anorectics.

CONTRAINDICATION: Desoxyn and Desbutal are contraindicated in patients taking a monoamine oxidase inhibitor.

PRECAUTIONS: Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs or ephedrine and its derivatives. Careful supervision is advisable with maladjusted individuals.



Gradumet—long-release dose form, Abbott: U.S. Pat. No. 2,987,445.
Sucaryl—Abbott brand of low and non-caloric sweeteners.

When depressed patients say:



"I can't sleep at night"



"I'm tired all day long"

NORPRAMIN[®]

(desipramine hydrochloride)

non-sedating • rapid-acting
ANTIDEPRESSANT

helps restore normal patterns of sleep and activity

Norpramin (desipramine hydrochloride) often reverses the signs and symptoms of depression including sleep disturbances, feeling of sadness, guilt, anxiety, worthlessness and bodily complaints without physical basis. In 2-5 days most patients become more hopeful, active and less weighed down by their problems.

Norpramin (desipramine hydrochloride) has only slight sedative qualities, nevertheless sleep disturbances and restlessness are relieved as depression is lifted. If anxiety or tension develop or persist a tranquilizer may be added or dosage reduced. Side effects are usually mild, occurring in about 1 of 4 patients.

Indications: In moderate to severe depression—neurotic or psychotic. **Dosage:** Optimal results are obtained at a dosage of two 25 mg. tablets t.i.d. (150 mg./day). **Contraindications and Precautions:** Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease and epilepsy. Should not be given within two weeks of an MAO inhibitor. Safety in human pregnancy has not been established. **Adverse Effects:** Usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste", sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs. **Supplied:** Norpramin (desipramine hydrochloride) tablets of 25 mg., in bottles of 50, 500 and 1000.

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Ballast Point Manor

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Care of mild mental cases, senile disorders and invalids.
Alcoholics treated. Aged adjudged cases will be accepted on
either permanent or temporary basis.



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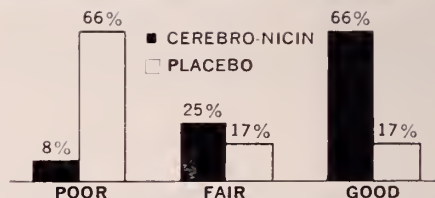
A nonprofit-voluntary hospital for the treatment of nervous and mental disorders and the problems of drug addiction and alcoholic habitation. Modern diagnostic and treatment procedures including—Psychotherapy, Insulin, & Electroshock, when indicated. Adequate facilities for recreation and out-door activities. Admissions are made without regard to race, color or national origin.

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For the treatment of
**apathy
irritability
forgetfulness
confusion**
in the aging patient

Cerebro-Nicin®

A GENTLE CEREBRAL STIMULANT AND VASODILATOR



CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jnl. of the Amer. Ger. Soc., June, 1964.

Write for literature and samples...

BROWN

THE BROWN PHARMACEUTICAL CO.

2500 W. Sixth Street,
Los Angeles, California 90057



EACH CEREBRO-NICIN CAPSULE CONTAINS:

Pentamethylene Tetrazole	100 mg
Nicotinic Acid	100 mg
Ascorbic Acid	100 mg
Thiamine HCl	25 mg
l-Glutamic Acid	50 mg
Niacinamide	5 mg
Riboflavin	2 mg
Pyridoxine	2 mg

DOSAGE: One capsule t.i.d. or as prescribed by physician.
AVAILABLE: Bottles of 100, 500, 1000 capsules.
Also elixir pint bottles.

CONTRAINDICATIONS: There are no known contraindications to Pentamethylene Tetrazole although caution should be exercised when treating patients with a low convulsive threshold. Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.
Federal law prohibits dispensing without a prescription.

QUIETS PHONES
QUIETS PARENTS
QUIETS **COLIC**



In colicky infants Pediatric Piptal with Phenobarbital slows down spasm, diminishes pain and crying and improves feeding patterns. It permits sleep and rest for patient and family. The less than hypnotic amount of phenobarbital in the recommended dose affords a mild, calming action and enhances the antispasmodic action of Piptal (pipenzolate bromide). The latter drug, as reported in the medical literature, has a favorable ratio of effectiveness to side-effects which is unusual in anticholinergics and thus is particularly appropriate to pediatric use.

**PEDIATRIC PIPTAL®
WITH
PHENOBARBITAL**

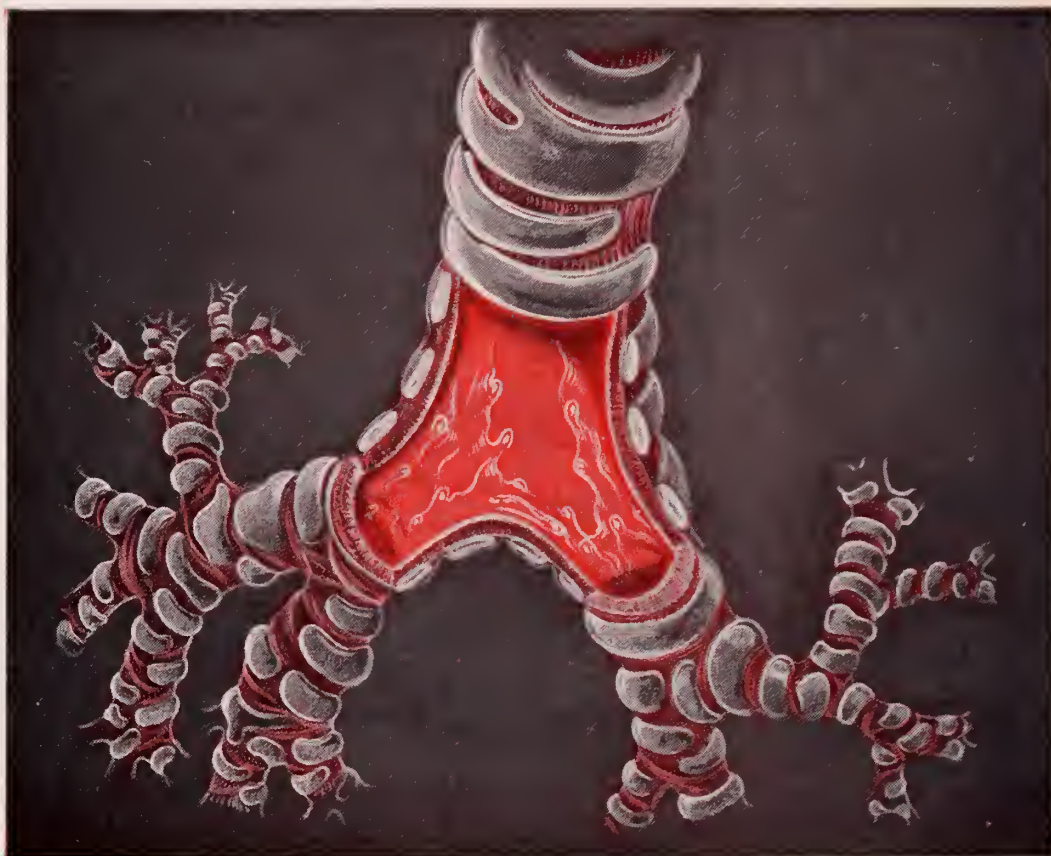
each cc. contains 6 mg. phenobarbital (warning: may be habit forming); 4 mg. Piptal® (pipenzolate bromide), and 20% alcohol.

Pleasant-tasting Pediatric Piptal with Phenobarbital is miscible in milk, formulas and fruit juices, and may also be given by dropper directly on the infant's tongue. Dosage is 0.5 cc. 15 minutes before feeding; in severe cases, 1.0 cc. four times daily. High doses may occasionally cause constipation with tenesmus and, rarely, flushing without fever. It is contraindicated in bowel obstruction or sensitivity to phenobarbital or anticholinergics. Available in 30 cc. dropper bottles, droppers calibrated to deliver 0.5 cc.

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ACTIVATE MUCUS LIQUEFACTION in Bronchitis, Sinusitis, Asthma with well-tolerated **IDO-NIACIN**[®]

Each Slosol coated tablet contains
Potassium Iodide 135 mg. and
Niacinamide Hydroiodide 25 mg.

Taste-free Iodo-Niacin provides mucus liquefying KI in a palatable form which on prolonged use greatly reduces the possibility of iodism.

In *The Pharmacologic Basis of Therapeutics*, Goodman and Gilman affirm, "Iodide salts are useful expectorants when it is desired to liquefy tenacious bronchial secretions, for example, in the later states of bronchitis, bronchiectasis, and asthma." Ed. 3, New York, Macmillan, 1965, p. 815.

When discussing symptomatic therapy of status asthmaticus, Hildreth recently stated, "There is little evidence that any expectorant other than potassium iodide is of practical value in this situation." Hildreth, E. A., *Postgrad. Med.*, 38:460 (Nov.) 1965.

When Iodo-Niacin was used for iodide therapy

continuously for over one year, symptoms of iodism were predominantly absent or of minor extent.

Dosage and how supplied: Adults—two tablets after meals taken with water. Children over eight years—one tablet after meals with water. Available in bottles of 100.

Caution: Serious side effects from Iodo-Niacin are rare. Caution is recommended in persons with known sensitivity to iodides. Pulmonary tuberculosis is considered a contraindication to the use of iodides by some authorities, and should be used with caution in such cases. As with all drugs, Iodo-Niacin may cause an idiosyncrasy in some patients. Rare cases of goiter with hypothyroidism have been reported in adults and in newborn infants of mothers taking iodides for prolonged periods. Use appropriate precaution in pregnancy and in individuals receiving Iodo-Niacin for prolonged periods.



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GENERAL PRACTITIONER OR INTERNIST for association with mixed group. Salary plus percentage and all expenses. Share coverage on days off, weekends, vacations. Guarantee \$20,000 first year. Contact T. C. Kenaston Jr., M.D., Box 550, Cocoa 32922, phone (305) 636-4221.

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GENERAL PRACTITIONER WANTED: Orlando, Orange County, East Central. Florida license required. Full time opening in county-supported medical clinic. Contact B. S. Webster, M.D., Medical Director, Orange County Medical Clinic, 832 W. Central Ave., Orlando 32805. Phone 241-4311, ext. 364.

GENERAL PRACTITIONER OR INTERNIST: Medical offices available November 1. One to four doctors accommodated. Modern structure with many medical facilities among tenants. Heart of Winter Park, Florida. Telephone: 644-8217. Write: c/o 240 New England Building.

EXCELLENT OPPORTUNITY for general practitioner in community of 15,000; central Florida; 76 bed JCAH hospital. Write or call collect R. C. Thompson, Bartow Memorial Hospital, Bartow, Fla.

GENERAL PRACTITIONER wanted for association with established young G.P. or to rent excellent office space in growing community. New hospital under construction nearby. Write G. L. Ehringer, M.D., 1370 Ocean Shore Blvd., Ormond Beach, Fla. or phone 677-2902.

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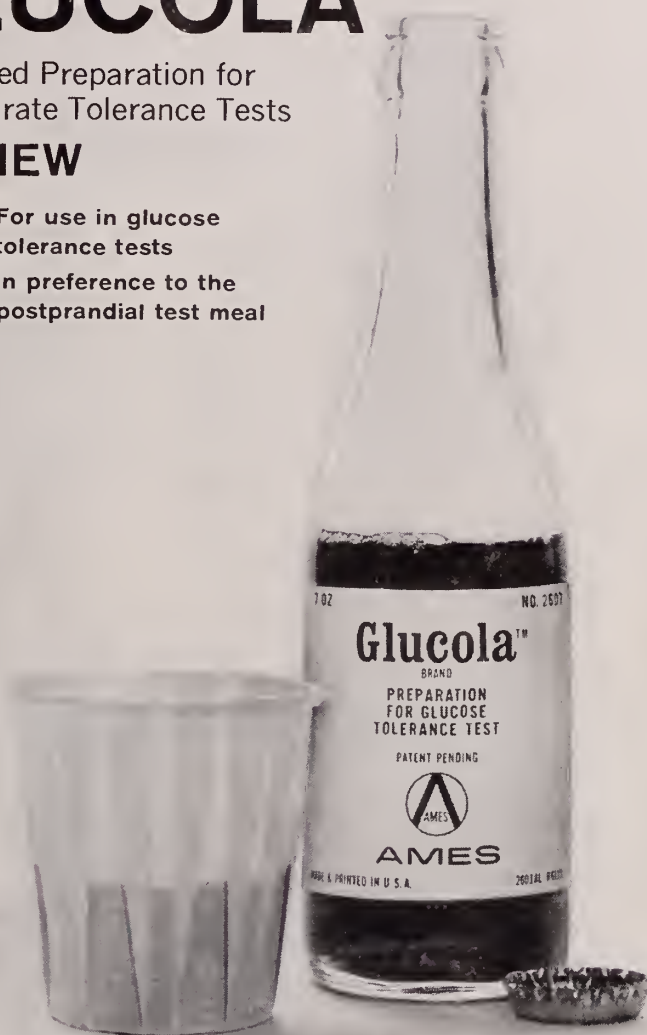
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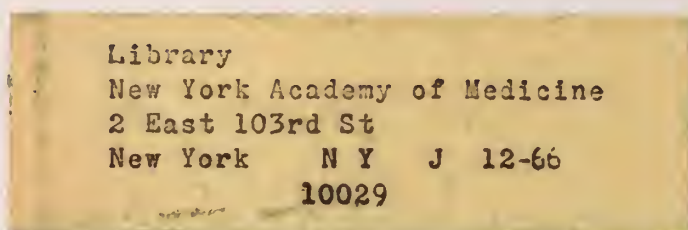
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DECEMBER, 1966

Volume 53

Number 12

BALCONY

The

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May 11-14, 1967
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Parkinsonism

Valvular Insufficiency

Hypertrophy of the Heart

Skin Tumors in South Florida

Obstructive Pulmonary Disease

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Corcoran, A. C.: The choice of drugs in the treatment of hypertension. In: *Drugs of Choice* 1966-67, W. Modell, Ed., St. Louis, C. V. Mosby Company, 1966, p. 417.

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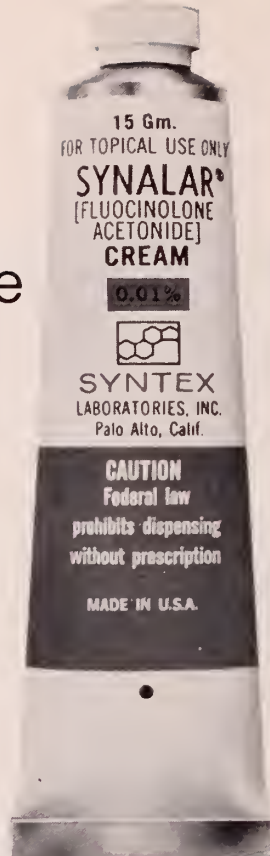
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Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella) Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of its components. **Precautions:** 1. *General*—Synalar Cream 0.01% is virtually nonsensitizing and nonirritating. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to

have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. 2. *Occlusive dressing method*—With occlusion of extensive areas, systemic absorption of the corticosteroid may occur, and special precautions should be taken. Occasional patients may show contact sensitivity to a particular dressing material or adhesive. Miliaria, folliculitis, pyodermas have been seen infrequently with the use of this technique. Development of infection requires appropriate antibacterial therapy. Continuation of the occlusive dressing method. Local atrophy and telangiectases have been reported with protracted occlusive dressing therapy. While relapses can be expected to occur in many psoriatic patients, relapses may persist for several weeks to several months in favorable cases. A patient whose psoriasis is in an active stage, with recent appearance of lesions, may not be a good candidate and may show early relapse. Plastic films may be flammable, and due care should be exercised in their use. Similarly, caution should be employed when such films are used on the face of children to avoid the possibility of accidental suffocation. **Effects:** Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. **References:** 1. Cahn, M. J. *Levy, E. J.* *J New Drugs* 1:262 (Nov.-Dec.) 1961. 2. Meenan, F. O. *Med Ass* 52:75 (Mar.) 1963. 3. Robinson, H. M., Jr., Raskin, J., and DeWitt, J. R. *Southern Med J* 56:797 (Jul.) 1963.

f a modern orticosteroid economy of ydrocortisone

v...a choice of 3
nomical sizes



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45 Gm. tube

fluocinolone acetonide — an original steroid from

SYNTEX 

LABORATORIES INC., PALO ALTO, CALIF.

Norinyl[®] tablets

(norethindrone 2 mg, \bar{c} mestranol 0.1 mg.)

for multiple contraceptive action that has produced a record of unexcelled effectiveness

inhibition of ovulation by means of

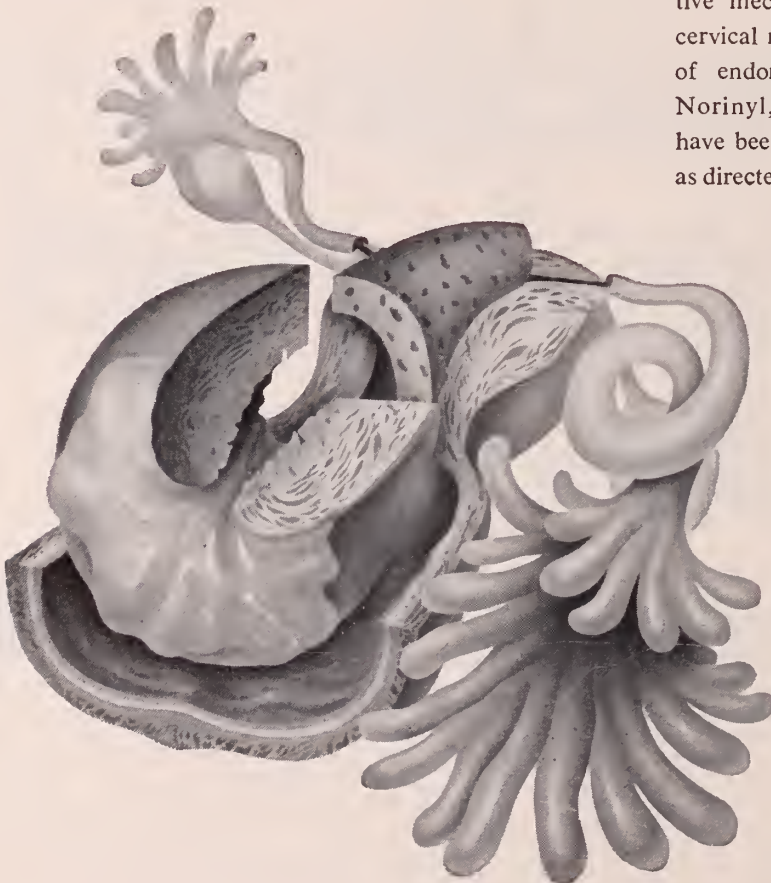
2 time-proved hormonal agents

production of a cervical mucus hostile to sperm motility and vitality

creation of an endometrium unreceptive to egg implantation

no unplanned pregnancies

Norinyl provides multiple action for maximum assurance of success. It does not depend on ovulation inhibition alone for contraceptive effectiveness. The mechanism of action of combined hormonal therapy results in ovulation inhibition reinforced by other protective mechanisms, including a hostile cervical mucus¹⁻¹³ and an acceleration of endometrial changes.^{1-3,7-16} With Norinyl, no unplanned pregnancies have been reported to date when used as directed.



plus important supportive benefits that help her through those critical early months of oral contraception

low incidence of side effects

Low incidence of BTB and spotting, nausea and amenorrhea tends to minimize side effect problems and increases patient cooperation.

no confusion about dosage

An unbreakable "confusionproof" package makes it easy to adhere to prescribed dosage schedule: individually sealed tablets numbered from 1 through 20 *plus* monthly calendar record enables patient to double-check dosage intake by day and corresponding tablet number.



Contraindications: Thrombophlebitis or pulmonary embolism (current or past). Existing evidence does not support a causal relationship between use of Norinyl and development of thromboembolism. While a study which was conducted does not resolve definitively the possible etiologic relationship between progestational agents and intravascular clotting, it tends to con-

firm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.

Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-

ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism. Side Effects: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: 1. Council on Drugs. JAMA 187:664 (Feb. 29) 1964. 2. Bryans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. 3. Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. 4. Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. 5. Hammond, D. O.: Ibid. 6. Rice-Wray, E.: Goldzieher, J. W., and Aranda-Roselli, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. 7. Goldzieher, J. W., Mases, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. 8. Kempers, R. O.: GP 29:88 (Jan.) 1964. 9. Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. 10. Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. 11. Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 29) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964. 16. Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

norethindrone—an original steroid from
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LABORATORIES INC. PALO ALTO, CALIF.

Norinyl® tablets
(norethindrone 2 mg. & mestranol 0.1 mg.)

for multiple contraceptive action





It's a Mrs. Smith, Doctor Harris.
Something about postnasal drip.

When you're called upon to provide quick relief for the sinusitis patient, Novahistine Singlet will usually do the job.

A single tablet provides prompt analgesic effect for relief of sinusitis pain. Then Novahistine Singlet also attacks the underlying cause of the headache—helping to open blocked respiratory passages and restore normal sinus drainage. The continuous decongestant effect produced by one Novahistine Singlet every 8 hours helps reduce the chance of acute sinusitis progressing to chronic stages.

Use cautiously in patients with severe

hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that Novahistine may occasionally cause drowsiness. Each tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.

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SINGLET^(TM)

For relief of sinusitis pain and congestion.



PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis

*A Key Site of Action of the
Protoveratrine A in Salutensin*

"The main function of the
carotid sinus is regulation of
the blood pressure...."¹

The veratrum component of
Salutensin acts here (and in the
myocardium), initiating
"...a reflex fall in blood pressure
through a generalized vaso-
dilation and fall in heart rate."²



This is a logical Blood Pressure Regulator

**BECAUSE
IT ENHANCES
THE BODY'S OWN
MECHANISMS
FOR REDUCING
BLOOD PRESSURE**

In mild to moderate hypertension:

Salutensin enhances the body's own mechanisms for lowering blood pressure. The veratrum component of Salutensin acts on the carotid sinus and myocardial receptors, initiating "...a reflex fall in blood pressure through a generalized vasodilation and fall in heart rate."² To achieve this reflex modification of hypertension, Salutensin utilizes protoveratrine A.

In addition, to facilitate and maintain blood pressure reduction, Salutensin incorporates reserpine and a highly effective thiazide. In general, side effects have been

reported infrequently but may include those listed in the therapeutic summary.

Simple dosage—low-cost therapy: Many patients on Salutensin respond to 1 tablet *b.i.d.* Long-term economy is assured, since dosage can frequently be lowered after initial control is established.

Available: Prescription-size bottles of 60 tablets.

References: 1. Editorial: *JAMA* 191:592 (Feb. 15) 1965. 2. Meilman, E., in Moyer, J.H.: *Hypertension*, Philadelphia, W.B. Saunders Company, 1959, p. 395.

BRISTOL THERAPEUTIC SUMMARY For complete information consult Official Package Circular.

Indications: Essential hypertension.

Warnings: Small-bowel lesions (obstruction, hemorrhage, perforation) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs.

Contraindications: Salutensin is contraindicated in severe depression.

Precautions: Azotemia, hyponatremia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss, which may cause digitalis intoxication, responds to potassium-rich foods, potassium chloride or, if necessary, stopping therapy. Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy two weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution with patients with peptic ulcers or renal insufficiency (if severe, Salutensin is contraindicated).

Side Effects: *Hydroflumethiazide:* Purpura plus or minus thrombocytopenia, hyperuricemia, leukopenia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)

Usual Dose: 1 tablet *b.i.d.*

BRISTOL BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York

Salutensin[®]

Each tablet contains:
protoveratrine A, 0.2 mg.;
hydroflumethiazide, 50 mg.;
reserpine, 0.125 mg.



Breast-feeding and the “modern mother”

Despite a mild resurgence of interest in the importance of breast-feeding a few years ago, many women today do not choose to nurse their young. This is for a variety of reasons—social, economic, cultural and sometimes medical. In such cases the physician's task is to find the most suitable means of preventing lactation and easing the pain of breast engorgement.

The means of therapy

The value of hormone therapy for this indication is of course well established. Both androgen and estrogen are known to inhibit the production and secretion of the lactogenic hormone by the anterior pituitary. As estrogen levels decline sharply at parturition, lactogenesis is established. When androgen and estrogen are administered to the patient before the release of the lactogenic hormone lactation and breast engorgement are usually prevented.

The time of therapy

The time of administration of this combined medication is crucial; it must be given early enough to suppress the pituitary prolactin and last long enough to permit physiologic readjustment during the puerperium. Excellent results are most often seen when therapy is administered before the onset of the second stage of labor.

However, factors other than effectiveness must also be considered. The agent selected should not interfere in any way with parturition, subsequent uterine involution and the restoration of normal ovarian cyclic function. Furthermore, it should not cause rebound breast engorgement or other manifestations of hormonal imbalance.

A balanced formulation

Providing single-dose therapy for the prevention of lactation and breast engorgement, Deladumone OB is a potent androgen-estrogen combination with a prolonged action. The optimal balance of androgenic and estrogenic hormones achieved in this preparation minimizes the disadvantages inherent in single hormone therapy, such as rebound breast engorgement. Involution of the uterus and resumption of menstrual cycles are not affected.

As reported in a recent published study (Roser, D. M.: *Obstet. & Gynec.* 27:73, 1966), Deladumone OB provided good suppression of breast engorgement in 95.3% and suppression of lactation in 81.1% of 86 obstetrical patients. These results are in general agreement with those of many earlier investigations; in several studies this injectable androgen-estrogen combination proved to be superior to oral medication.

Dosage:

As a single injection of 2 cc. before the onset of the second stage of labor.

Contraindications:

Established or suspected mammary cancer or genital malignancy.

Precautions and Side Effects:

Certain patients may be unusually responsive to either estrogenic or androgenic therapy. In such individuals virilization, uterine bleeding or mastodynia may occur.

Supply:

Deladumone OB, providing 180 mg. testosterone enanthate and 8 mg. estradiol valerate per cc., is available in 2 cc. Unimatic® disposable syringes and in 2 cc. vials. Both preparations are dissolved in sesame oil, with 2% benzyl alcohol as a preservative. *Before use, consult product literature for full prescribing information.*

Deladumone® OB

Squibb Testosterone Enanthate (180 mg./cc.) and Estradiol Valerate (8 mg./cc.)

Single-dose injection for lactation inhibition

SQUIBB



'The Priceless Ingredient' of every product is the honor and integrity of its maker.



Now, now, Mrs. Forsythe, we've never lost a cold patient yet.

When she's experiencing acute discomfort from cold symptoms, it's small wonder the patient becomes distressed about her condition.

She will breathe easier when you prescribe Novahistine LP. Novahistine LP is a long-acting decongestant that helps restore normal mucus secretion and ciliary activity—physiologic mechanisms which prevent infection of the respiratory tract. A dose of two tablets taken in the morning and repeated in the evening will usually keep air passages clear for 24 hours.

Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention.

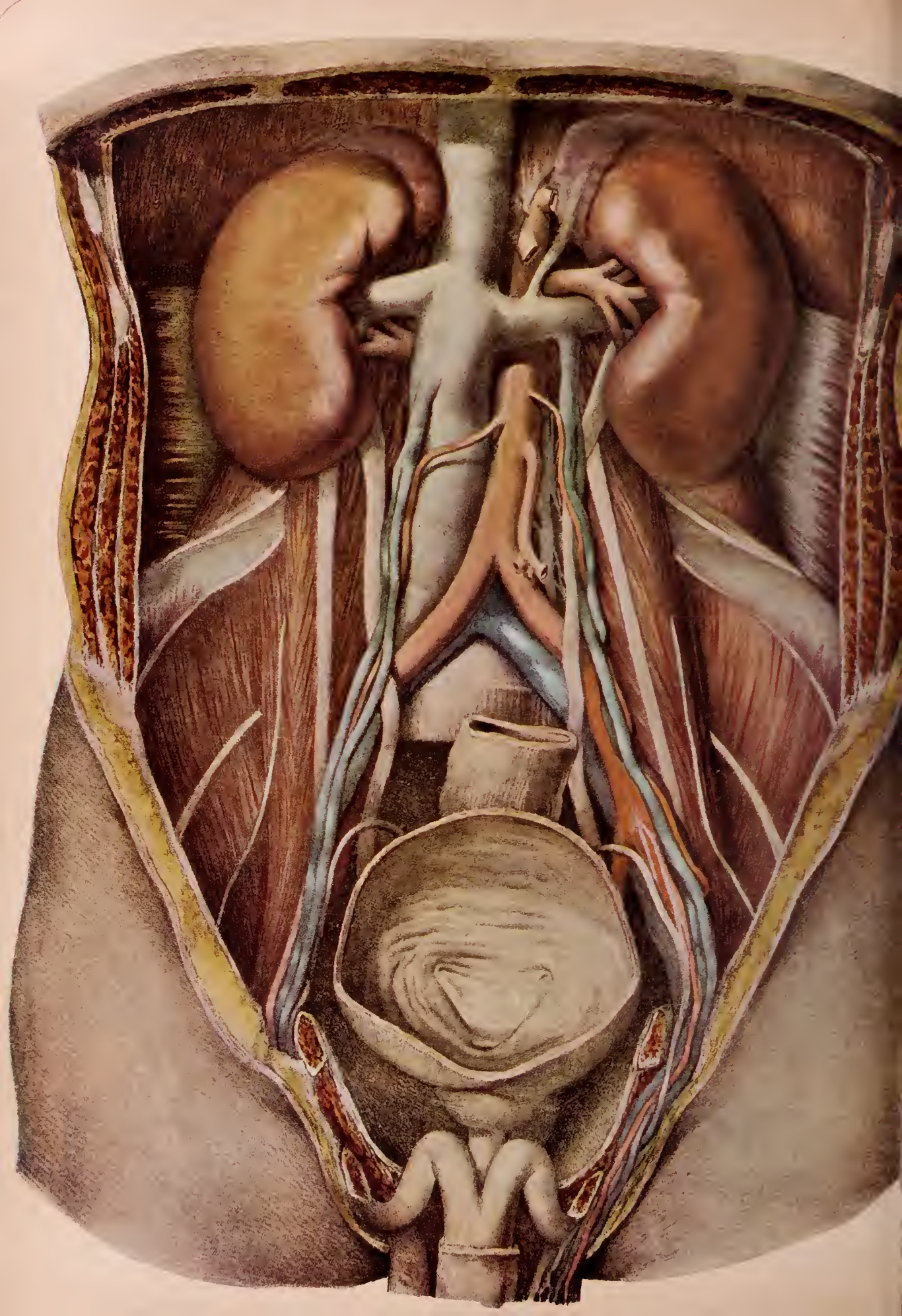
Caution patients who operate machinery or motor vehicles that drowsiness may result.

Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis 

NOVAHISTINE® LP

For relief of nasal congestion.



Wide-range bactericidal action for genitourinary infections

NEW OMNIPEN[®] (AMPICILLIN) WYETH

A penicillin that exhibits effectiveness within the gram-positive spectrum of penicillin G* and the gram-negative spectrum of chloramphenicol and the tetracyclines.*

Active at foci of infections—kidney, ureter, bladder or urethra.

Effective against many gram-negative and gram-positive pathogens—thus may be valuable not only in genitourinary but also in common respiratory and gastrointestinal infections.

Normally produces high and persistent levels in blood and high concentrations in bile and urine.

Significant inherent stability.

**Exclusive of penicillinase-producing bacteria.*

Indications: Urinary tract infections, especially those caused by *E. coli*, *Proteus mirabilis*, and *Streptococcus faecalis* and *viridans*; respiratory infections caused by *H. influenzae*, pneumococci, streptococci, and nonpenicillinase-producing staphylococci; and gastrointestinal infections caused by *Shigella* and *Salmonella*, including *Sal. typhosa*.



Contraindications: Hypersensitivity to penicillin; infections due to penicillinase-producing staphylococci and other penicillinase-producing bacteria.

Precautions: If allergic reaction occurs, discontinue ampicillin and administer epinephrine, corticosteroids, antihistamines and/or pressor amines as indicated. Transient moderate

elevation of SGOT values of undetermined significance was noted in a few infants. Liver and kidney function as well as hematopoietic tests are advisable during therapy, particularly in infants. As with other antibiotics, precautions should be taken against gastrointestinal superinfection. Safety for use in pregnancy has not been established.

Adverse Reactions: Occasional mild side effects as urticaria, skin rash, pruritus, diarrhea, nausea and vomiting. There have been no reports of blood dyscrasias, liver or kidney damage. Anaphylaxis has been reported.

Composition: Capsules, 250 mg.
**American Hospital Formulary
Service Category No. 8:12.16.**

Wyeth Laboratories Philadelphia, Pa.





"Yes, Doctor, the pain is gone."

■ Despite introduction of synthetic substitutes, efficacy of 'Empirin' Compound with Codeine remains unchallenged.

'Empirin'® Compound with Codeine Phosphate gr. ½ No. 3

Each tablet contains: Codeine Phosphate gr. ½ (Warning—May be habit forming), Phenacetin gr. 2½, Aspirin gr. 3½, Caffeine gr. ½.

Keeps the Promise of Pain Relief



BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.

Frankly, most antihypertensives are pretty good if you give an adequate dose. I'm looking for one with a simple regimen so that mix-ups in doses and therefore the chance of side effects are minimized.



Regroton®

chlorthalidone 50 mg, reserpine 0.25 mg.

**1 tablet daily
brings pressure down**

Advantage: Both components of Regroton are long-acting.

Average dosage: One tablet daily with breakfast.

Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.

Warning: Discontinue 2 weeks before general anesthesia, 1 week before electroshock therapy, and if depression or peptic ulcer occurs. With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.

Precautions: Reduce dosage of concomitant antihypertensive agents by one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitals. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.

Side effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.

For full details, see the complete prescribing information.

Availability: Bottles of 100 and 1000 tablets.

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only one in the morning 

and one in the evening 

Now b.i.d. convenience plus even greater patient savings over q.i.d. tetracycline therapy

(plus all the advantages of
tetracycline phosphate complex)

new Tetrex® bidCAPS* (tetracycline phosphate complex)

Maximum patient savings. New bidCAPS now enable you to prescribe tetracycline in an even more economical, more convenient form. Your patient's prescription dollar gets maximum value: a daily bidCAPS dose is priced lower than any other leading brand of tetracycline—b.i.d. or q.i.d.

Well tolerated. Tetrex (tetracycline phosphate complex) is well tolerated. Gastrointestinal side effects are few; photodynamic reactions are extremely rare.

More of the active antibiotic in the blood. The basic tetracycline in Tetrex (tetracycline phosphate complex) is less bound to serum protein than is demethylchlortetracycline.¹ Result: Tetrex (tetracycline phosphate complex) provides a higher percentage of active antibiotic in the blood.

Available in bottles of 16 and 50.



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Syracuse, New York

BRISTOL THERAPEUTIC SUMMARY: For complete information consult Official Package Circular. **Indications:** Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms. **Contraindications:** The drug is contraindicated in individuals hypersensitive to tetracycline. **Warnings:** Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discoloration occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). **Precautions:** Mycotic or bacterial superinfection may occur. Infants may develop increased intracranial pressure with bulging fontanelles. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. **Adverse Reactions:** Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis and allergic reactions may occur. **Usual Adult Dose:** 500 mg. b.i.d. Continue therapy for 10 days in beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals.

Reference: 1. Roberts, C. E., Jr.; Perry, D. M.; Kuhoric, H. A., and Kirby, W. M. M. A. M. A. Arch. Int. Med. 107:204 (Feb.) 1961.

bidCAPS is a trademark of Bristol Laboratories, Division of Bristol-Myers Company, for its brands of twice-a-day capsules. Each Tetrex bidCAP contains Tetrex (tetracycline phosphate complex) equivalent to 500 mg. tetracycline HCl activity.

**How long will
it take her
to recover from
her hip fracture
if she just
doesn't care?**



Does she really care?
Is she alert, encouraged,
positive and optimistic
without getting completely
tired soon?

Or has she given in to
the demoralizing impact
of confinement, disability
and dependency?

When functional fatigue
complicates convalescence,
Alertonic can help...

Pleasant-tasting Alertonic is pipradrol hydrochloride—an effective cerebral stimulant whose gentle analeptic action helps counteract the apathy and inertia that can often delay convalescence—together with an excellent vitamin and mineral formula, in a satisfying 15% alcohol vehicle.

Nothing fosters confidence and a sense of well-being better than your own personal warmth, understanding and encouragement together with Alertonic to help insure prompt response.

*Adequate dosage is important: Prescribe Alertonic—
one tablespoonful t.i.d., 30 minutes before
meals...tastes best chilled.*

*And for your patient's sake, prescribe Alertonic
in the convenient, economical one-pint bottle.*

Alertonic[®]

Available Only On Prescription

Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%; pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin B₁) (10 MDR*), 10 mg.; riboflavin (vitamin B₂) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin B₆), 1 mg.; niacinamide (5 MDR), 50 mg.; choline,† 100 mg.; inositol,† 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.

†The need for these substances in human nutrition has not been established.

Indications: 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

Contraindications: As with other drugs with CNS stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive compulsive states.

Side effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Merrell

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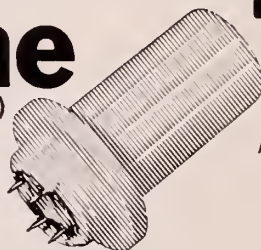
what time is it?

For the past
two years
there's been
one new case
of active tuberculosis
reported for every
four thousand
of U.S. population.

it's time to tine.

Tuberculin, Tine Test

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SOLVES THE
PROBLEM

for the infant
who requires a
milk-free diet!



- Soyalac satisfies! Baby is happy, mother is grateful, doctor is gratified.
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- Soyalac is strikingly similar to mother's milk in composition and ease of assimilation. Clinical data furnish evidence of Soyalac's value in promoting normal growth and development.
- Excellent for regular infant feeding, too—and for growing children and adults.

Free Booklet and Samples

A request on your professional letterhead or prescription form will bring to you complete information and a supply of samples.



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A special letter-number symbol will appear on each Lilly capsule or tablet. By checking this code against the *Identi-Code Index*, you will be able to identify each unit quickly and accurately:

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A complete explanation of Identi-Code and its use is provided in the *Identi-Code Index*. If you have not yet received an index, your Lilly representative will be pleased to supply you with a copy.

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Cineangiographic Evaluation of Valvular Insufficiency

FRANK LaCAMERA JR., M.D.

Our modern era of surgical replacement of heart valves presents a paradox. All too often patients are allowed to continue their present medical management of rheumatic heart disease without taking advantage of newer surgical techniques. On the other hand, many physicians have a tendency to recommend valve replacement too often without knowing all the facts. Frequently patients are sent to a medical center, physically and mentally prepared for surgery, only to be turned down by the surgeon or cardiologist who thinks the problem may be too complex or the lesions not sufficiently severe for the surgical risk involved. Because routine methods of cardiac evaluation such as physical examinations, x-rays and electrocardiograms may not be enough to give a definite answer, we utilize the more sophisticated phonocardiograms, vectorcardiograms and heart catheterizations. The catheter can tell us the degree of valvular stenosis easily, but it gives less than ideal information about valvular insufficiency.

During heart catheterization the use of cineangiographic visualization of the valve function gives the most precise data available regarding valvular incompetence. These data are even superior to the surgeon's evaluation at the operating table because the heart is in a more normal physiological state during catheterization when the patient is not under the effects of drugs or anesthesia.

Utilizing 35 mm. x-ray motion picture films, a 5 inch image intensifier and 90% Hypaque as the contrast medium, cineangiograms were made of the valves of six patients. Studies of one patient revealed the presence of moderate tricuspid insufficiency, mitral stenosis and no mitral insufficiency. Because of the lack of mitral insufficiency, the surgeon decided to perform a routine commissurotomy rather than open heart surgery. A child with an interatrial septal defect had no mitral insufficiency thus permitting the surgeon to perform the operation with less concern than if this combination of defects had existed. In one patient aortic insufficiency developed following open heart surgery for aortic stenosis. The cineangiograms revealed an insufficient amount of aortic regurgitation to cause the tremendous left

Director, Cardiovascular Laboratory, Rogers Heart Foundation, St. Petersburg.
Read before the Florida Medical Association, Ninety-Second Annual Meeting, Hollywood, May 13, 1966.

ventricular enlargement that was present. Thus surgery was avoided, and several years later the boy died of myocardial disease unrelated to the aortic insufficiency.

Another patient had severe mitral stenosis. The cineangiograms revealed minimal aortic insufficiency and no mitral insufficiency; therefore, the surgeon elected to perform a mitral commissurotomy knowing that the aortic valve lesion was minimal. Cineangiograms revealed the presence of moderate mitral insufficiency and moderate aortic insufficiency in a patient with severe mitral stenosis. This finding alerted the surgeon to be prepared to replace the aortic valve as well as the mitral valve at the time of open heart surgery. A sixth patient was studied prior to open heart surgery for severe mitral stenosis. The cineangio-

grams revealed moderately severe mitral insufficiency and minimal aortic insufficiency; therefore, the surgeon was permitted to operate upon the mitral valve without concern about the necessity of operating upon the aortic valve at the same time.

With each of these six patients decisions regarding the necessity of surgery or regarding the type of surgical approach could be made with more certainty and accuracy by studying cineangiograms. By utilizing regular diagnostic tools and heart catheterization we can be reasonably accurate in our diagnosis of valvular insufficiency, but it is cineangiography that gives us the most thorough evaluation of valvular insufficiency.

► Dr. LaCamera, 500 First Federal Building, St. Petersburg 33701.

Deadline Nears For Annual Meeting Scientific Papers and Exhibits

Applications are now being accepted for scientific papers and exhibits to be presented before the 93rd Annual Meeting of the Florida Medical Association, May 11-14 at the Americana Hotel, Bal Harbour. Applications were included in the September Briefs. Additional applications may be obtained by writing Russell B. Carson, M.D., Chairman, Committee on Scientific Work, P.O. Box 2411, Jacksonville, Florida 32203.

Applications must be submitted no later than January 1, 1967. The Committee on Scientific Work will make selections and notify contributors of acceptance shortly thereafter.

Important Note: All applications for scientific papers to be presented before the 93rd Annual Meeting of the Florida Medical Association must be accompanied by a one page (200 word) summary of the paper prepared for publication in the Journal of the Florida Medical Association. These summaries will be published in the Journal prior to the Annual Meeting.

Idiopathic Ventricular Hypertrophy of the Heart

LEONARD S. SOMMER, M.D.

Hypertrophy of the ventricles is a useful mechanism of the heart to compensate for valvular and other disorders; it may even be a natural response to exercise and work, as in the professional athlete. In certain instances of heart disease, however, ventricular hypertrophy may become a primary pathologic disorder, leading to all the manifestations of cardiac dysfunction and death. The causes of idiopathic ventricular hypertrophy are not known, but as rheumatic, hypertensive and syphilitic heart disease diminishes in numbers, this entity will become more important to recognize early, diagnose precisely and treat rationally.

Several kinds of idiopathic ventricular hypertrophy or enlargement have been described, which in the past have been difficult to differentiate. Modern cardiovascular diagnosis with combined use of hemodynamic and angiographic techniques has made possible the precise in vivo characterization of these conditions. Of 18 patients with idiopathic ventricular enlargement recently studied in the Cardiovascular Laboratory of the University of Miami, four examples are presented to demonstrate the variety of manifestations and certain aspects of management.

Report of Cases

Case 1.—A 47 year old woman was evaluated because of easy fatigability and exertional dyspnea. Atrial fibril-

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lation had become persistent six months earlier, at which time attempted reversion to sinus rhythm was unsuccessful and was complicated by systemic embolization. On admission, the rhythm was irregular, rate 76. The apical first heart sound was accentuated with a discrete apical impulse and diastolic thrill. No murmur was audible. Blood pressure was 110/80 mm. Hg. The chest films (fig. 1) revealed calcification in the mitral valve region and enlargement of the left atrium and both ventricles. The electrocardiogram (fig. 2) showed atrial fibrillation, left ventricular hypertrophy and strain, and an axis of $+15$ degrees. Cardiac catheterization-cineangiographic studies revealed elevated diastolic pressure in each ventricle with a "constrictive" hemodynamic pattern, pulmonary hypertension, marked decrease in cardiac output and a small systolic pressure gradient between the left ventricle and the systemic artery. The left ventricle presented a slitlike cavity with marked hypertrophy of its septum and free wall. The patient subsequently underwent film-changer angiocardiology, which revealed, in addition, right ventricular hypertrophy (fig. 3). She remained moderately limited though able to work until her sudden death three years later from an acute cerebral hemorrhage. At autopsy both ventricles were markedly hypertrophied and the mitral valve ring and leaflets were calcified.

This patient represents an example of severe, diffuse biventricular hypertrophy with inflow obstruction due to reduced compliance of the ventricular musculature and stenosis of the mitral orifice. Outflow obstruction was also present. Calcification in the mitral valve is occasionally associated with this myocardial disorder and may lead to erroneous diagnosis of rheumatic mitral valve disease.

Case 2.—A 64 year old man had progressive increase in symptoms of exertional dyspnea, weakness, angina pectoris, syncope and recurrent acute pulmonary edema. Physical examination suggested the presence of aortic stenosis, the murmur being loudest at the lower left sternal border and apex. X-ray studies (fig. 4) revealed slight cardiac enlargement with a left ventricular contour. An electrocardiogram (fig. 5) demonstrated left bundle



Fig. 1

branch block, first degree atrioventricular block and left ventricular hypertrophy. Cardiac catheterization and cineangiography revealed severe muscular subaortic stenosis due to marked muscle hypertrophy; the systolic pressure gradient was increased by the administration of sublingual nitroglycerin and was significantly reduced by the intravenous infusion of a beta-sympatholytic agent, Inderal (Ayerst). The patient's digitalis preparation was discontinued and he has been maintained on treatment with oral Inderal with complete disappearance of his symptoms.

This patient represents an example of severe obstructive hypertrophy of the interventricular septum, which was benefited by discontinuing digitalis and treatment with a beta-sympatholytic agent. There has been complete control of symptoms on this therapeutic regimen, with dramatic disappearance of angina pectoris, syncope and recurrent pulmonary edema.

Case 3.—A 43 year old man complained of recurrent palpitations associated with dizziness, especially on suddenly arising. There was a strong familial history of cardiopathy as follows: One twin son died suddenly at age 15 while running at school; autopsy examination revealed marked hypertrophy of both ventricles and bulging of the interventricular septum. His surviving identical twin was

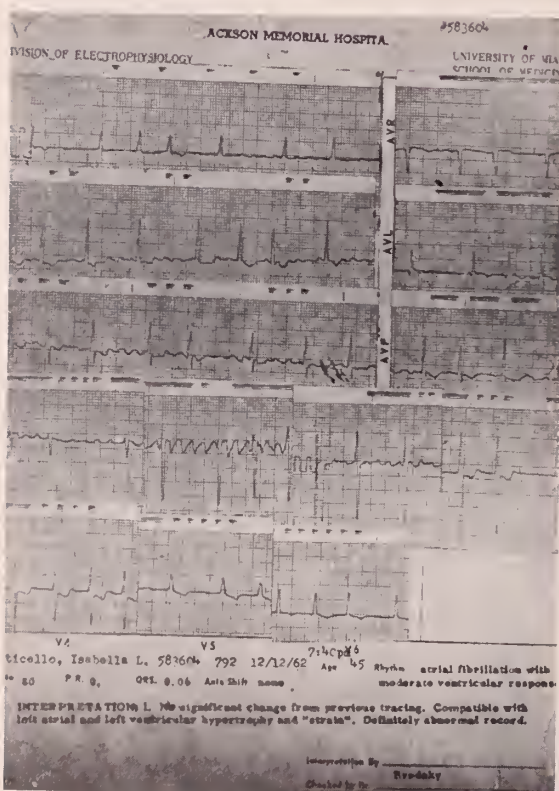


Fig. 2

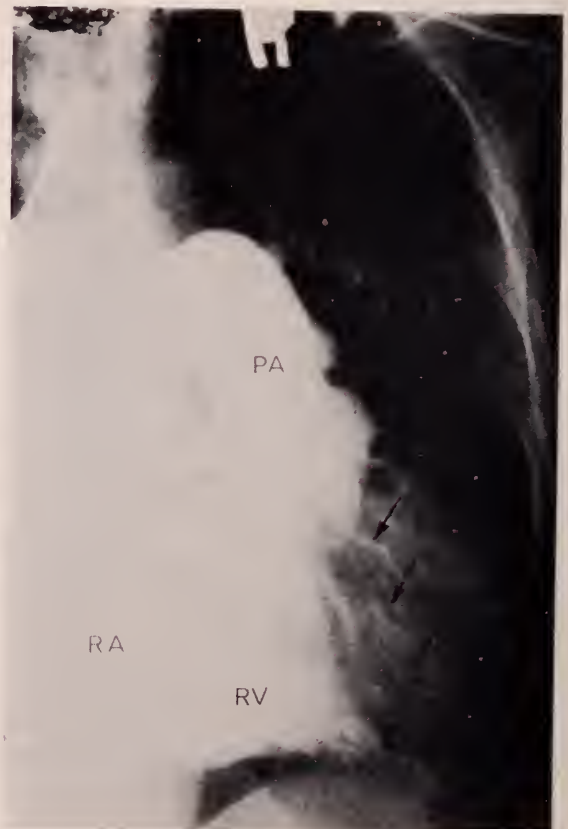


Fig. 3

evaluated shortly thereafter and found to have mild sub-aortic stenosis. The patient's daughter, aged 22, has no evidence of heart disease. On examination there was a prominent left ventricular impulse and first heart sound. Chest x-rays demonstrated no cardiac abnormality. The electrocardiogram (fig. 6) showed evidence of left ventricular hypertrophy and strain. Cardiac catheterization-cineangiographic studies revealed evidence of left ventricular dysfunction (elevated diastolic pressure and reduced cardiac output) with slight enlargement of this chamber; selective coronary arteriography demonstrated an anomaly of the coronary arteries, with the circumflex division filling as a branch of the dominant right coronary artery, and the anterior descending division arising as an isolated vessel from the left sinus of Valsalva. No hemodynamic evidence of left ventricular outflow obstruction could be provoked. The patient was therefore digitalized and has improved clinically.

This patient represents an example of left ventricular dysfunction without obstruction to flow, and presents a familial history of cardiopathy with sudden death. The use of digitalis was associated with disappearance of the palpitations and clinical improvement in the symptoms.

Case 4.—A 46 year old man was evaluated because of progressive exertional dyspnea, orthopnea and pedal edema. There was a history of recurrent atrial fibrillation. A son has Ebstein's disease of the tricuspid valve. Physical examination revealed a pectus deformity of the chest, irregular heart rhythm and a diastolic third heart sound. An electrocardiogram (fig. 7) showed atrial fibrillation and left bundle branch block. X-rays revealed left atrial enlargement and initially bilateral pleural effusions. Cardiac catheterization-cineangiographic study demonstrated slight cardiac dysfunction (normal output and elevated left ventricular filling pressure); following electrical conversion to sinus rhythm, cardiac function returned to normal values except for reduced output response to exercise. There were left atrial dilatation and considerable left ventricular hypertrophy with bulging of the interventricular septum. The patient became asymptomatic until atrial fibrillation recurred a month following hospital discharge.

This patient has idiopathic left ventricular hypertrophy with recurrent atrial fibrillation associated with congestive heart failure. There is



Fig. 4

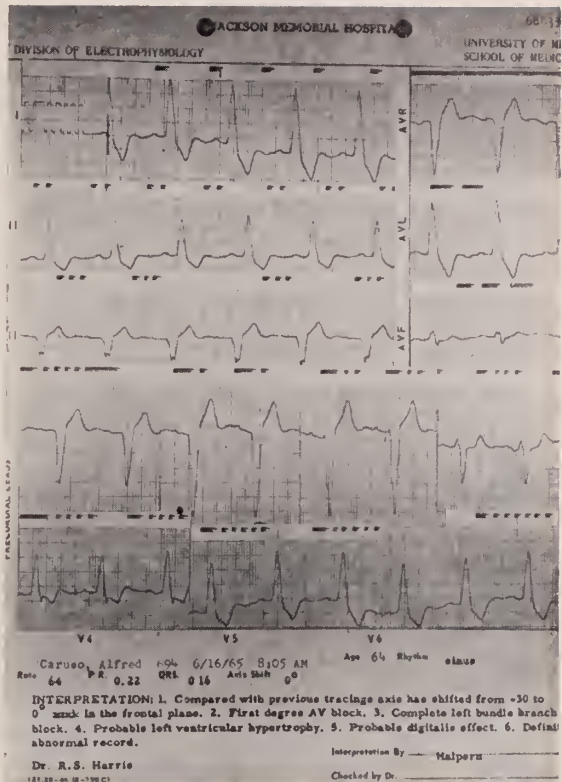


Fig. 5

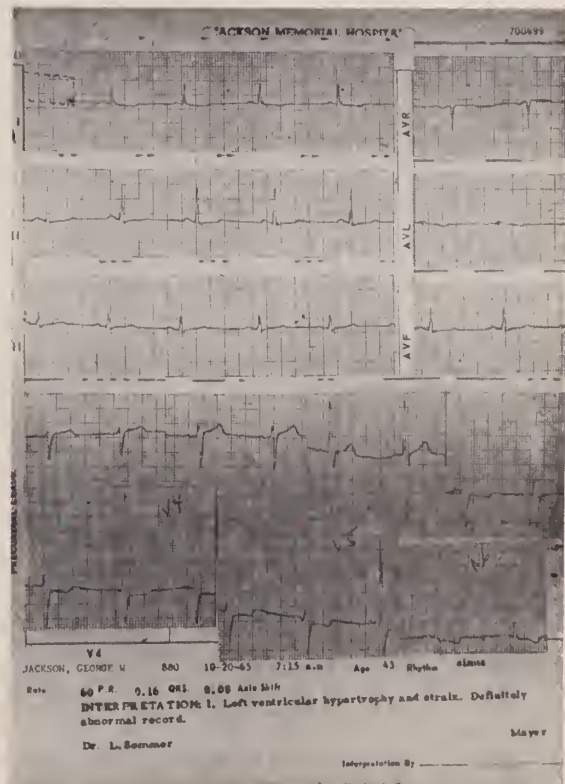


Fig. 6

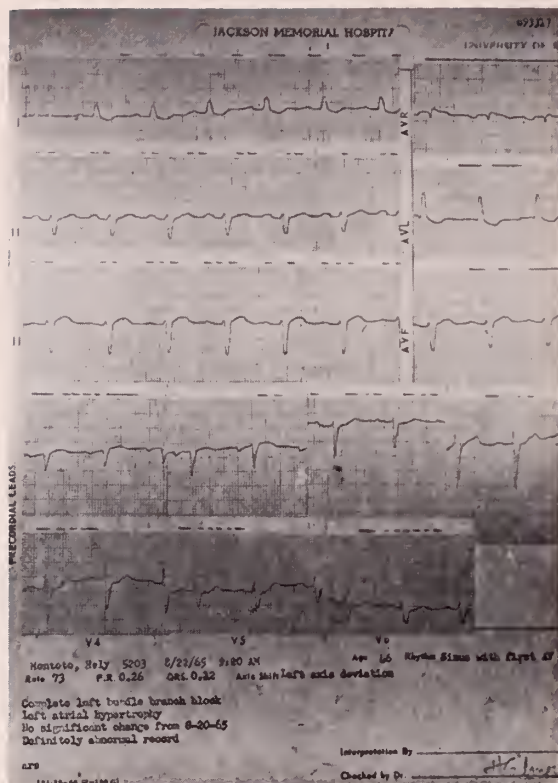


Fig. 7

a family history of congenital heart disease. Rhythm conversion to a sinus mechanism is beneficial although the arrhythmia tends to relapse.

Discussion

Patients with left ventricular enlargement or hypertrophy may present several different hemodynamic and angiographic profiles. After separating those with primarily valvular and coronary atherosclerotic disease, it is essential that patients with idiopathic ventricular hypertrophy be char-

acterized as to the presence or absence of muscular obstructive phenomena and with regard to the status of left ventricular function. The role of paroxysmal or persistent arrhythmias must also be considered in relation to causation of disabling symptoms. Rational therapy can be based on an evaluation of the angiographic anatomy and the hemodynamic response to brief, acute pharmacologic provocations or rhythm conversion, as demonstrated in the case histories given. In the presence of muscular outflow obstruction, digitalis and nitrite drugs may be contraindicated while a beta-sympatholytic agent may be beneficial. In its absence, and in the control of paroxysmal arrhythmias, digitalis may be beneficial. Conversion of persistent arrhythmias to sinus rhythm may be of therapeutic benefit in improving ventricular function.

Summary

Idiopathic ventricular enlargement or hypertrophy presents a variety of anatomic and functional patterns. Examples are described of diffuse, obstructive muscular hypertrophy associated with calcific mitral stenosis simulating rheumatic heart disease in which surgery would not be feasible; localized, muscular obstruction in the outflow tract of the left ventricle closely simulating aortic stenosis; left ventricular dysfunction without obstruction associated with probable paroxysmal arrhythmia; and ventricular hypertrophy associated with persistent arrhythmia. Rational therapy was based on analysis of the angiographic and hemodynamic observations.

Reference

Wolstenholme, G. E. W.: *Cardiomyopathies*, Ciba Foundation Symposium, Boston, Little Brown and Company, 1964.

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Nebulization Inhalation Therapy And Postural Drainage In The Treatment Of Chronic Obstructive Pulmonary Disease

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Inhalation therapy has been used empirically in the treatment of chronic obstructive pulmonary disease for many years. Nebulization or aerosol therapy which is an important type of inhalation therapy has also been used, but in an unsophisticated manner. As a result, there has been considerable disagreement as to the efficacy of such measures as humidity control, heated nebulizer inhalations, mist tents and aerosol medications. Most investigators who have carried out careful studies agree on the efficacy of these therapeutic measures, but there can be little doubt that effective utilization of nebulization therapy requires an understanding of the basic physical principles involved as well as knowledge of the pathology and pathophysiology of the disease under treatment. Most of the disagreement about the efficacy of this form of therapy is the result of failure to apply available knowledge of (1) the structure and function of the respiratory tract in relation to the inhalation of nebulized material, (2) the physics involved in particle distribution and deposition and (3) the site of deposition of inhaled particulate matter in the tracheobronchial tree.

Objectives

The objectives of nebulization therapy are to wet and thin respiratory mucous secretions and to

deposit locally effective topical agents (decongestants, bronchodilators, mucolytic agents and antibiotics) directly on the mucous membranes of the tracheobronchial tree. Nebulization therapy should not be confused with humidification. Humidity is a measure of the amount of water existing in the gaseous phase in air. Humidification of inspired air affects the upper respiratory tract and trachea, but since all inspired air is normally warmed to 37° C. and 98-100% humidified before it reaches the bifurcation of the trachea, the humidity of inspired air has no effect on the peripheral bronchi and bronchioles. They are always filled with humidified air. The aim of nebulization therapy is the provision of particles of water or of water containing medication for deposition at various levels in the respiratory tract depending on the site of the disease process. This site of deposition is largely dependent on particle size, and this is determined by the nebulizers used, by the composition and vapor tension of the solution nebulized, and by the humidity of the air used to produce nebulization or to carry the mist to the patient.

Physical Principles

The physical principles governing the deposition of particulate material in the lung have been intensively studied. Large particles 60-10 μ in diameter are largely deposited by inertial impaction. These particles, because they have large mass, develop large inertial forces in the high velocity air flow of the upper respiratory tract.

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Because of this inertia, they fail to transverse the bends in the upper airways, impinge on the mucosal surfaces and deposit. Indeed, few particles over 10μ in diameter penetrate beyond the larynx. Particles $10\text{--}1\mu$ in diameter also deposit by inertial impaction but as the particle size and mass decrease, sedimentation, or fall-out, becomes the primary mechanism of deposition. These particles, having less mass, are carried along in the air stream until it slows as the repeated branching of the bronchial tree occurs. Gravity acting on the particles then causes them to deposit on the mucosal surface. Obviously, the larger the particle in this range the higher it will deposit in the bronchial tree. Particles $3\text{--}1\mu$ in diameter reach the smaller bronchioles. Brownian motion is relatively unimportant but is the primary mechanism for deposition of particles under 1μ in diameter. It occurs only in the respiratory bronchioles and alveolar areas where air flow is very slow.

Utilization

In utilizing nebulization therapy it is essential that a nebulizer be selected which will provide the proper particle size for the disease being treated. This statement is valid only if particle size is stabilized by humidifying the carrier air or by reducing the vapor tension of the nebulized solution. When such stability is provided for particle size determines the site of deposition. It is futile in treating disease in the trachea or major bronchi to use a nebulizer that provides a very small particle size mist since 99% of the particles under 6μ in diameter will pass the involved area without depositing. Similarly, it is futile to use a large particle mist generator to treat disease in the lower respiratory tract since the large particles will deposit before they reach the diseased area. To treat adequately the pulmonary lesion of cystic fibrosis, asthma or asthmatic bronchitis where involvement begins in the smaller bronchioles and extends towards the larger bronchi, it is essential to use a nebulizer which produces a mist made up of particles in the $5\text{--}1\mu$ range.

The composition and size stability of the particle are also important. As the air carrying a mist is inhaled it is warmed to 37°C . and 100% humidified. This humidification results from evapo-

ration of water from the mucous membrane of the upper airways and from the mist particles if plain water is nebulized. Since evaporation is proportional to surface area and the surface area of the millions of small particles is large compared to the surface area of the upper respiratory tract, nebulized water particles will evaporate to humidify the air in the upper tract instead of depositing on the mucous membrane in the lower tract. Using jet-type nebulizers that produce a $1\text{--}10\mu$ particle size mist, the densest mist obtainable when dispersed at equilibrium in a mist tent, contains only slightly more particulate water than is required to humidify completely air raised in temperature from 22°C . to 37°C . This is particularly true when the humidity of environmental air is low.

This evaporation of the nebulized particles can be prevented by reducing the vapor tension of the water with propylene glycol. A concentration of 10% propylene glycol in water is selected since this concentration yields a solution which is, for practical purposes, in equilibrium with an atmosphere which is 99% saturated with water at 37°C . In higher concentrations propylene glycol is hydrophilic or attracts water to make the particle grow and in lower concentrations it does not effectively reduce evaporation. In 10% concentration it tends to stabilize particle size.

Osmolarity is also important. Pulmonary secretions are iso-osmolar. If large amounts of distilled water or hypertonic solutions are added to them, the result is mucosal irritation.

The quantity of nebulized particles or density of the mist produced determines the therapeutic effectiveness. If an adequate quantity of water or medication is not inhaled and deposited, therapy will obviously be ineffective. Output of a nebulizer is therefore an important consideration as is the density of the mist in a mist tent. To be effective in wetting secretions, the mist in a tent should be so dense that it is difficult to see the patient in the tent.

Other factors also affect the deposition of nebulized particles in the respiratory tract. Size of the respiratory tract is important. The smaller the bronchial tree the greater the deposition at any given particle size and the smaller the particles needed to reach the bronchioles. Respiratory

rate and depth of respiration also influence deposition. The slower the rate and the deeper the breath the greater the deposition.

In general, nebulization therapy can be divided into two types: mist tent therapy, which is used for prolonged periods of nebulization therapy; and intermittent aerosol therapy, which is usually used to administer medication over brief periods several times daily.

Mist Tent Therapy

Mist tent therapy is used to add large amounts of water to tracheobronchial secretions to liquefy them and by so doing to promote their drainage and assist the normal mucociliary mechanism in removing them from the tracheobronchial tree.

In utilizing mist tent therapy one must consider the environmental humidity, the size of the tent and how air-tight it is, the air flow from the nebulizers and the water output of the nebulizers. In our hospital during the late fall, winter and early spring respiratory disease seasons, the temperature is kept around 22° C. and the relative humidity is about 10%. This air will be humidified to 100% as it passes through the nebulizer if plain water is nebulized. This change requires 0.017 Gm. of water per liter of air flow through the nebulizer. Further evaporation then occurs in the tent to maintain the humidity of the air in the tent at 100%. The air inhaled by the patient is warmed to 37° C. and 100% humidified at that temperature. The total amount of water needed to maintain humidity at 100% as the temperature of inhaled air is raised to 37° C. is 0.024 Gm./liter if the mist tent temperature is 22° C. Thus, above and beyond the humidity of the room air, a total of over 0.041 Gm. of water/liter of air inhaled is needed just for humidification.

How much water exists in the air in a mist tent? This is a difficult figure to ascertain. We know how much is put in per minute; but like O₂, this particulate water is constantly being forced out of the tent by air flow and, simultaneously, humidity or gaseous water is diffusing out of the tent. The resulting loss of water from the tent varies markedly depending on how air-tight it is, on the environmental humidity and on the mattress. Diffusion is inversely proportional to the square root of molecular weight. Oxygen is almost twice as heavy as H₂O. We know that a 100% O₂ flow into a tent at a rate of 16 liters/min.

maintains an O₂ concentration of 50% or less. This would indicate that the loss of water from a tent in the gaseous form is significant and that the concentration of water in the air in the tent will be considerably less than the concentration in the air entering the tent from the nebulizer.

Both air flow and water output must be considered in utilizing mist tent therapy. Air flow determines the rate of equilibration and, in general, the higher the rate of air flow the closer the equilibration water density will be to that in the nebulizer air stream. Air flow through a DeVilbiss Ultrasonic Nebulizer averages 32 liters/min. and the units provide a 2 cc./min. output at the 2 position, a 4 cc./min. output at the 3 position and a 6-7 cc./min. output at the 4 position or 0.063 Gm./liter at 2, 0.125 Gm./liter at 3, and 0.188-0.2 Gm./liter at the 4 position. At any of these settings an adequate air flow is entering the tent to result in rapid equilibration and an adequate amount of water (more than 0.041 Gm./liter) should exist in the air in the tent to provide for complete humidification plus a residual mist for deposition.

In contrast, the output of the MG 11 C Mist O₂Gen units we have been using in our mist tents is only 0.5-0.6 cc./6 liters of air flow per minute or 0.1 Gm. of water/liter of air flow/min. When air flow and water output are both considered this is obviously inadequate. Even when two such units are used in a tent a significant visible fog is not produced at room temperature if plain water is nebulized. To obtain a dense mist using these nebulizers the mist must be stabilized to prevent evaporation. Stabilization is accomplished by reducing the vapor tension of the water in the particles with propylene glycol. When concentration of 10% propylene glycol is used, the upper airways provide most of the water for the humidification of inspired air and the particles are preserved to deposit in the lower tracheobronchial tree.

From these studies it is obvious that the equipment necessary for effective mist tent therapy is determined by the particle size desired and by the density of mist desired. In treating patients with obstructive pulmonary disease, we recommend an ultrasonic nebulizer if a very dense

mist is needed. Where lesser density is adequate, 2 MG 11 C Mist O₂Gen nebulizers are adequate if a solution of 10% propylene glycol in distilled water is nebulized. Both types of nebulizers provide a small 1-5 μ particle size. A compressor, or source of compressed air, is essential if the jet-type nebulizers are used. A plastic tent and a cooling unit or room air-conditioner are needed regardless of the nebulizer used. It should always be kept in mind that the human body will increase the temperature of a tent above environmental temperature and that loss of body heat by evaporation is markedly decreased in a mist tent. Adequate temperature control can be achieved by either cooling the tent to 70° F. or reducing the environmental temperature to 62-65° F.

The solution to be nebulized depends on the nebulizer used. We have found a solution of 10% USP Propylene Glycol in distilled water to be superior to all other solutions for the treatment of most patients when the jet-type nebulizers are used. A solution of 10% propylene glycol in 3% NaCl can be used to liquefy secretions more rapidly, but is irritating if used for more than a week or two. If an ultrasonic nebulizer is used propylene glycol is not necessary, but distilled water in a dense mist is very irritating. Normal saline is well tolerated but becomes irritating over a long period. We now initiate therapy with normal saline and then decrease the concentration to one-half strength for long term therapy. An occasional patient is sensitive to propylene glycol, requiring use of the ultrasonic nebulizer. Some asthmatic patients react to any inhaled particulate material. This form of therapy is contraindicated in such patients.

As a result of our pulmonary function test evaluation of mist tent therapy in patients with cystic fibrosis, we now use the mist tent prophylactically as well as therapeutically. In using it therapeutically during the period of initial intensive hospital therapy or during acute flare-ups of the pulmonary lesion, we keep the patient in the mist tent from 10 to 18 hours out of every 24 hours. In general, the smaller the child the longer the daily period of therapy. Prophylactically, we use it only during sleeping hours. All of our patients with cystic fibrosis who now have, or who have ever had evidence of pulmonary involvement sleep in mist tents every night at home. We

have also had excellent results in treating asthmatic bronchitis, asthma, bronchitis and chronic pulmonary disease due to neuromuscular disease.

We have used and evaluated mist tent therapy since Dr. Robert Denton introduced us to it in 1957 when we were initiating our attempt to develop a better treatment program for children with cystic fibrosis. In our initial evaluation 20 patients were started on a complete therapeutic program except for use of the mist tent. Pulmonary function studies were obtained every three months for three consecutive periods. At the end of this nine month period, mist tent therapy utilizing 2 MG 11 C Mist O₂Gen nebulizers nebulizing 10% propylene glycol in distilled water, was added to the treatment program. Repeat pulmonary function studies were performed two months later and then at four to five month intervals over the next year.

This experimental design uses the patient as his own control. By analyzing the differences occurring over the serial control intervals before and after addition or elimination of a therapeutic measure, it is possible to determine the random variation due to the uneven course of the disease, and to compare this variation with the changes produced by introducing or removing an individual therapeutic measure. During the three periods before introduction of the mist tent some random variation occurred, but these changes cancelled each other and no significant changes were observed. In contrast, when the mist tent was added significant changes in the direction of improvement were observed for all of the parameters measured except for vital capacity. All of the patients utilized in this study had relatively mild disease and only small deficits in vital capacity so failure to produce a significant change in vital capacity was not surprising. The changes seen in FRC, RV, the ratio of RV to total lung capacity and in MBC were all significant at the 0.01 level of probability. This improvement was then largely maintained with continued use of the mist tent and again no significant changes were observed over a one year follow-up period.

A similar study was carried out on 16 patients who were placed on the entire therapeutic program including mist tent therapy. After their condition stabilized as shown by pulmonary function testing over three consecutive control peri-

ods, the mist tent was eliminated from the treatment program for one month. This alteration resulted in significant changes, all in the direction of increased airway obstruction and air-trapping. They were then returned to their mist tents and pulmonary function tests two months later revealed quantitative reversal of these changes. Tests over two subsequent control intervals again revealed no significant changes.

Recently, a similarly designed study aimed at determining whether mist tent therapy utilizing a DeVilbiss 400 ultrasonic nebulizer nebulizing normal saline was superior to our regular mist tent therapy was completed. For this study 41 patients were selected who had persistently abnormal pulmonary function tests despite intensive, continuous home therapy including the use of a regular mist tent. All of these patients were in relatively stable control as shown by pulmonary function tests obtained at three month intervals for at least six months before the study was initiated. The only changes made in studying the efficacy of the DeVilbiss ultrasonic nebulizer were substitution of this nebulizer for a one month period for the two jet-type nebulizers normally used, and a change from 10% propylene glycol in distilled water to normal saline as the nebulized solution. A previous study utilizing the jet-type nebulizer to compare these two solutions yielded superior results with the 10% propylene glycol in distilled water.

The experimental design in this study was similar to that described. These patients all had advanced pulmonary disease; so a tendency toward progression was seen in the mean differences for vital capacity and MBC during the second control interval. In contrast, after one month of therapy with the ultrasonic nebulizer, marked changes all in the direction of improvement and all statistically significant at the 0.005 level of probability were seen for all the parameters measured. Quantitative reversal of these changes was then observed in tests performed one month after return to the regular mist tent.

The results of these three studies confirm our clinical observations and provide objective evidence of the value of mist tent therapy in the treatment of obstructive airway disease and of the superiority of the ultrasonic nebulizer over the jet-type nebulizer at least for the short term treat-

ment of patients with advanced pulmonary disease due to cystic fibrosis.

Studies are now in progress to determine the long term efficacy of ultrasonic mist tent therapy on 16 of these patients with cystic fibrosis. These patients all have advanced pulmonary disease which was progressing at the time ultrasonic mist tent therapy was initiated. After an average follow-up period of five months, 10 are improved, four unchanged and two worse.

Intermittent Aerosol Therapy

The second form of nebulization therapy is intermittent aerosol therapy. The chief purpose of this form of therapy is the local deposition of medication in the tracheobronchial tree. To decrease edema, thus opening the airway and promoting removal of secretions, we use $\frac{1}{8}\%$ Neo-Synephrine. To relieve bronchospasm we use a 1:200 solution of isoproterenol. To prevent or stop the growth of bacteria in the mucous secretions, antibiotics are added. To date we have not found an effective mucolytic agent.

In general, we use the ET 1 F Mist O₂Gette nebulizer or the Bennet twin jet nebulizer with a non-rebreathing Bennet face mask or a plastic mouthpiece for all aerosol therapy. The nebulizer is operated by the same air compressor used for the mist tent therapy. In a few selected cases we use IPPB therapy to administer the aerosol; however, this is used only in the hospital and only on patients old enough to permit the frequent evaluation of therapy by pulmonary function studies. In our pulmonary function test evaluation of IPPB therapy, we found that indiscriminate use resulted in increased air-trapping and did more harm than good.

The solutions we use for aerosol therapy vary with the pathologic condition being treated. The basic solution used on almost all patients is 10% USP Propylene Glycol in $\frac{1}{8}\%$ Neo-Synephrine. Where bronchospasm exists, 0.1-0.5 ml. of a 1:200 solution of isoproterenol is substituted for an equal volume of the basic solution. In many cases, antibiotics such as sodium methicillin (Staphicillin), neomycin, and polymyxin are also added.

All of our patients with cystic fibrosis, and most of our patients with other forms of obstructive pulmonary diseases, are now on daily aerosol

therapy. Usually, it is administered three to four times daily, immediately preceding postural drainage. This form of therapy is used to open up the respiratory tract, and by so doing to facilitate drainage and improve the efficacy of the cough. It is also employed both prophylactically and therapeutically.

Oxygen Therapy

Oxygen therapy should also be included in a discussion of inhalation therapy. Chronic obstructive pulmonary disease can, during acute exacerbations and when advanced, produce severe hypoxia. In addition to the obvious effects of hypoxia, it, and the respiratory acidosis which usually accompanies it, result in increased pulmonary vascular resistance and cor pulmonale. Increasing the O_2 content of inspired air will decrease this hypoxia and often decrease pulmonary vascular resistance. This is particularly true if continued use of nebulization therapy and postural drainage achieves better ventilation which reduces the accumulation of CO_2 and the associated respiratory acidosis.

Oxygen therapy, if not used carefully, can be harmful or even lethal. High concentrations of O_2 in the alveoli predispose the patient to atelectasis. If, as a result of chronic exposure to a high pCO_2 , the respiratory center has become insensitive to CO_2 and is responding only to the hypoxic stimulus, elimination of this stimulus may result in cessation of respiration or in such respiratory depression that the resulting CO_2 accumulation and respiratory acidosis defeat all the purposes for which oxygen was given. We limit the O_2 content of our tents to 40% and raise it slowly to this level, simultaneously monitoring the effect on arterial pO_2 , pCO_2 , and pH. Used in this manner, oxygen can be of great value.

Cleaning the Lungs

Up to this point therapy has been aimed at wetting and thinning the pulmonary secretions and opening up the respiratory tract. The next step is the removal of excess secretions from the tracheobronchial tree. To assist the normal mechanisms of pulmonary hygiene in accomplishing this objective, segmental postural drainage is employed on all patients three to four times daily using the British system. All parents and/or patients are trained during the initial hospitalization

and subsequently carry on this therapy daily at home. Care is taken to position the patient so as to drain each major segment of the lung and, in particular, to drain the more involved segments. While the patient is in each position, the segmental bronchi are treated like an almost empty catsup bottle. The therapist claps over them to jar loose any secretions and then vibrates the area on expiration to overcome inertia and increase the flow of secretions. This procedure both stimulates coughing and increases the effectiveness of the cough.

All of the patients are also taught breathing exercises to strengthen the respiratory muscles and to improve diaphragmatic respiration. These breathing exercises are practiced during aerosol therapy and postural drainage. The patient is taught to breathe slowly and deeply and to expire as fully as possible. This form of therapy is indicated whenever accumulation or excessive production of pulmonary secretions is part of the pathophysiology of the disease under treatment.

Other therapeutic measures can also be used to assist in keeping the lungs clean. Physical therapy has proved to be of significant therapeutic value. Exercises to mobilize the chest, to strengthen the accessory muscles of respiration and the cough muscles and to improve posture are employed. Physical activity is also helpful in stirring up and bringing up secretions. All of our patients are kept ambulatory and active if at all possible.

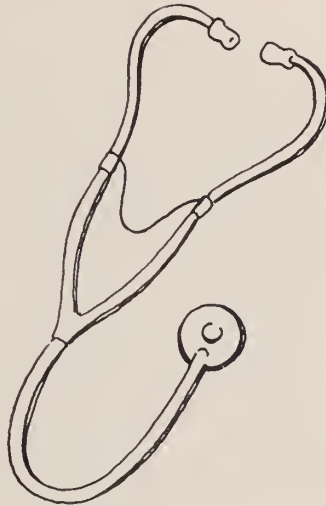
Expectorants have not proved of great value. Iodides are of some benefit when used in high dosages. In those patients with evidence of bronchospasm, the bronchodilator drugs such as ephedrine and theophylline are of some value. In treating children we have found it desirable to use ephedrine-phenobarbital or ephedrine-tranquilizer combinations and a separate theophylline preparation. This therapy permits increasing the dose of ephedrine without using toxic doses of theophylline.

Finally, the treatment of associated disease of the upper respiratory tract is of considerable importance. Any chronic disease of the upper respiratory tract will serve as a constant source of secretions and infection for the lower respiratory tract and should be eradicated if possible.

Obviously, all of the previously mentioned therapy is directed primarily at the accumulation of secretions in the tracheobronchial tree. This therapy was discussed in detail because we believe it is of primary importance and is essential for effective antibiotic therapy. If we can drain or clean out the tracheobronchial tree, we can usually eliminate both infection and hypersecretion. If we fail to clean up the lung, giving anti-

biotics is no more effective than throwing them into a stagnant swamp to sterilize the water. The principle of adequate drainage is an all important one, regardless of whether we are dealing with the middle ear, the sinuses, the genitourinary tract, an abscess or the tracheobronchial tree.

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Precancerous and Cancerous Skin Tumors Seen In South Florida In 1964

STANLEY I. CULLEN, M.D., GEORGE IOANNIDES, M.D.,
and ROBERT G. CARBAUGH, B.S.

It has been clearly shown that the incidence of skin cancer in any given area of the United States is inversely proportional to the distance of that area from the equator.¹ It has also been demonstrated that skin cancer is the most common cancer seen in white males in the southern portion of this country.²⁻⁵ Jackson Memorial Hospital is the southern-most hospital of its size in the Continental United States and it seemed worthwhile to compare and contrast various types of precancerous and cancerous skin lesions seen there during 1964. It was also thought worthwhile to determine any existing relationships of tumors to the patient's age, sex and race, and also the sites of tumor predilection.

Method

Biopsies with the histopathological diagnosis of basal cell carcinoma, squamous cell carcinoma, Bowen's disease, keratoacanthoma, cutaneous horn, erythroplasia of Queyrat, actinic keratosis and malignant melanoma were tabulated and their relationship to the patient's age, race and sex, and body site were recorded. The number of malignant tumors diagnosed during the same period of

time with a primary site other than skin was obtained from the hospital tumor registry. The Jackson Memorial Hospital tumor registry is an accredited registry approved by the Statistical Tabulating Center of the Florida State Board of Health.

Results

Cancer of the skin was the most common form of the disease seen at Jackson Memorial Hospital in 1964. It accounted for 28.7% of all malignant tumors seen in that year (fig. 1). The five leading organ systems of malignant tumor location were, in order of decreasing frequency, skin, respiratory system, female genital organs, digestive system and lymphatic and hematopoietic

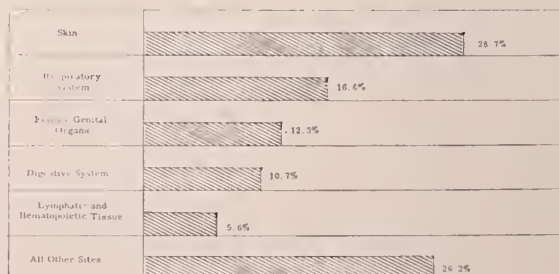


Fig. 1

This study was supported in part by Dermatology Training Grant 2A 5262 from the National Institute of Arthritis and Metabolic Diseases, National Institutes of Health. From the Department of Dermatology, University of Miami School of Medicine, and the Dermatology Foundation of Miami, Miami, Fla.

Table 1.—Malignant Tumor Distribution by Race, Sex and Primary Site

Primary Tumor Site	Number Tumors	% White Male	% White Female	% Negro Male	% Negro Female
Skin	371	60.6	36.4	1.4	1.6
Respiratory system	215	70.2	16.3	11.6	1.9
Female genital organs	160	—	63.8	—	36.2
Digestive system	138	52.2	30.0	9.4	9.4
Lymphatic and hematopoietic tissue	72	54.2	40.0	8.3	5.5
All other sites	338	44.7	34.3	10.9	10.1

tissue. Together, they accounted for approximately 75% of the malignant tumors seen at this hospital in 1964.

Table 1 represents 1,294 malignant tumors distributed by race, sex and primary site. Of these tumors, 638 were in white males; 451 in white females; 86 in Negro males, and 119 in Negro females. This table reveals that only 1.4% of the skin tumors occurred in Negro males and 1.6% in Negro females. Approximately 20% of the tumors occurring in other than cutaneous sites were in Negro patients. Nearly twice as many skin cancers occurred on white males as on white females.

Table 2 demonstrates that of a total of 358 patients with 459 lesions, 200 patients had 268 basal cell carcinomas. Of these 200 patients, 42 had more than one tumor removed during the year; of the 66 patients with 81 squamous cell carcinomas, 12 had more than one lesion removed during the year. It can be seen from these data that basal cell carcinomas comprise an overwhelming majority of the skin tumors biopsied at this hospital.

The age distribution of patients is depicted in table 3. The greatest number of cases of basal cell carcinoma occurred in the 60 to 69 year age

group. Only 3.5% of all the basal cell carcinomas occurred before the age of 40, with 67.9% occurring after the age of 60. The median age of male and female patients with basal cell carcinoma was respectively 66 and 67. In males, the incidence of squamous cell carcinoma reached its peak in the sixth decade of life, and in females in the eighth decade. The median age of male patients with squamous cell carcinoma was 66; the median age of female patients with squamous cell carcinoma was 71.

Table 4 presents an analysis of 485 cutaneous cancers distributed according to body site and correlated with the sex of the patient and the cell type of the tumor. The great majority of all skin cancers, 86%, occurred on the head and neck. A relatively greater proportion of the basal cell carcinomas occurred on the head and neck than squamous cell carcinomas, because of a greater proportion of squamous cell carcinomas located on the perineum and extremities. The most common site of basal cell carcinoma was the nose, upon which approximately 25% of the basal cell carcinomas occurred. The most common sites of squamous cell carcinoma were the cheeks, upon which 14% of these lesions occurred. Squamous cell carcinomas occurred with greater frequency than

Table 2.—Tumor Distribution by Race and Sex

TUMOR	Number Tumors	% White Males	% White Females	% Negro Males	% Negro Females
Basal cell carcinoma	268	57.7	39.2	0.7	0.4
Squamous cell carcinoma	81	67.9	24.7	3.7	3.7
Bowen's disease	17	52.9	47.1	0	0
Keratoacanthoma*	16	50.0	50.0	0	0
Cutaneous horn	6	66.7	33.3	0	0
Erythroplasia of Queyrat	1	100	0	0	0
Actinic keratosis	65	67.7	32.3	0	0
Malignant melanoma	5	20.0	40.0	0	40.0

*Keratoacanthomas are not premalignant lesions but are included here because of their many similar characteristics.

Table 3.—Patient Distribution by Decade*

Tumor	Sex	Number Patients	% 0-29	% 30-39	% 40-49	% 50-59	% 60-69	% 70-79	% 80-95
Basal cell carcinoma	M	162	0.6	2.5	12.3	19.1	29.0	24.1	12.3
	F	122	0	4.1	12.3	12.3	27.0	25.4	18.8
Squamous cell carcinoma	M	66	0	4.5	12.1	22.8	21.2	21.2	18.2
	F	26	0	0	15.4	26.9	3.8	30.8	23.1
Bowen's Disease		19	0	5.3	5.3	5.3	26.3	21.0	36.8
Keratoacanthoma		22	0	4.5	9.1	18.2	40.9	22.7	4.5
Actinic keratoses		73	0	4.1	1.4	20.5	21.9	32.9	24.7

*This table includes all patients with biopsies interpreted by the Pathology Department of Jackson Memorial Hospital (patients of Victoria Hospital and private outpatients included).

basal cell carcinomas in only two sites, the lower lip and the genital organs. Of 14 basal cell carcinomas on the lips, all were on the upper lip.

Female patients, in contrast to male patients, showed a lower incidence of cancer of the skin over the preauricular and postauricular areas, ears and temple regions. The frequency of squamous cell carcinoma on the lips of male patients was six and one-half times greater than that of female patients.

Of five patients with squamous cell carcinoma on the penis, four were uncircumcised.

Discussion

This study revealed a high relative incidence of skin cancer to cancer arising from other body sites. Over one fourth of all malignant tumors diagnosed at this hospital in 1964 were tumors of the skin.

This finding is in agreement with statistics given by the Department of Epidemiology of the University of Texas, M.D. Anderson Hospital, and Tumor Institute,⁶ in which of 30,000 patients with cancer seen from 1944 to 1961 at that institute, approximately 25% were seen for primary cancer of the skin.

The incidence of skin cancer in the general

population was determined for 10 major cities in different areas of this country by the National Institute of Health, United States Public Health Service, during the years of 1947 and 1948.^{2-5, 7-12} This report showed that the incidence of skin cancer was much higher in southern than northern cities and revealed that in white males skin cancer was the most common form of the disease in the Southern United States. The incidence rates per 100,000 population ranged from 123.2 for white males and 68.7 for white females in New Orleans, to 33.6 for white males and 24.2 for white females in Detroit.

The distribution of basal cell carcinomas with approximately 90% occurring on the head and neck is striking. A high incidence of skin cancer over these areas is to be expected, however, when one considers the sun exposure to these areas.

The fact that no basal cell carcinomas were on the lower lip might be explained on the basis of a variation of intensity of actinic radiation upon the two lips, the lower lip receiving a more intense radiation. While it is generally agreed that relatively high doses of skin irradiation frequently lead to the formation of squamous cell carcinomas, evidence has been presented that basal cell carcinomas are not infrequently seen in areas of chronic radiodermatitis.¹³ The partic-

Table 4.—Location of 485 Skin Cancers*

Tumor Site	Basal Cell Carcinoma				Squamous Cell Carcinoma				Total Carcinomas	
	Male No.	%	Female No.	%	Male No.	%	Female No.	%	No.	%
Head	186	86.9	132	89.8	64	74.4	20	52.6	402	82.9
Neck	4	1.9	4	2.7	4	4.7	3	7.9	15	3.1
Trunk	14	6.5	9	3.4	2	2.3	4	10.5	29	6.0
Extremities	10	4.7	2	1.4	10	11.6	3	7.9	25	5.1
Perineum	0	—	0	—	6	7.0	8	21.1	14	2.9
Total	214	100	147	100	86	100	38	100	485	100

*Includes all skin cancers with biopsies interpreted at Jackson Memorial Hospital in 1964 (patients of Victoria Hospital and private outpatients included).

ular body site irradiated also appears to have a bearing on what type of skin cancer may develop.¹³ Graham and McGauran¹⁴ presented evidence that for practical purposes, basal cell carcinomas occur only in skin containing sebaceous glands and that the frequency of this tumor in exposed skin is directly proportional to the gland density.

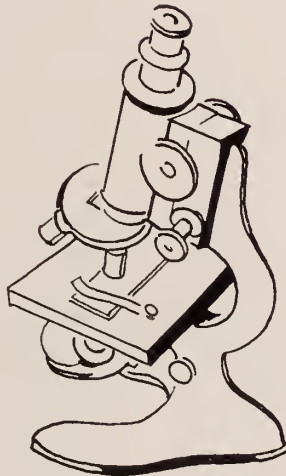
Summary

A statistical tabulation of various types of precancerous and cancerous skin lesions diagnosed histopathologically at Jackson Memorial Hospital

during 1964 is presented. A high relative incidence of skin cancer (28.7%) is shown to prevail at this hospital with the great majority of the skin cancers being of the basal cell type. Skin cancer is shown to be primarily a disease of Caucasian males of retirement age. A high relative incidence of skin cancer in males with the majority of tumors located on exposed areas of the skin conforms with the hypothesis of actinic radiation being involved in their etiology.

References are available from the authors upon request.

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Long Term Results in the Surgical Treatment Of Parkinsonism

IRWIN PERLMUTTER, M.D. and DAVID FAIRMAN, M.D.

The aim of surgery in the treatment of parkinsonism is to relieve the motor disability of the patient by relieving the hyperkinetic symptoms. Diminution or abolition of tremor and rigidity can restore a patient from inevitable invalidism to independence.

By January 1965, 265 patients had been operated on by us and have been observed for postoperative periods ranging from six months to eight years. Results have been satisfactory in about 75% of this series of parkinsonian patients with partial or complete relief of tremor and rigidity.

The type and degree of benefit to the patient have been in relation to the type and stage of development of the previously existing syndrome and to the entire constellation of signs and symptoms in each patient. Some patients in this series have been extended the opportunity of surgery despite certain complicating intracerebral problems, such as hydrocephalus ex-vacuo which made pin point physiological localization of the lesion site less than optimal. With strict adherence to criteria for patient selection, to be discussed later, a 90% satisfactory result level is certainly achievable surgically. Patients with intracerebral problems, complicating the exact localization of lesion site, certainly tend to bring down the average.

One postoperative death occurred in our series; a 70 year old man had a myocardial infarction the day after operation. No patient had hemiplegia.

Surgical Method

A well defined lesion of predetermined size is produced within the subcortical structures by applying the stereotactic apparatus and technique originated by one of us in 1957.¹ The destruction of subcortical structures is accomplished by high frequency coagulation. The unipolar technique has proved particularly suitable for coagulation because it insures a quantitative relation between the strength of the high frequency current, the active surface of the electrode used and the volume of coagulation produced. The localization and size of the lesion have been confirmed in each case by injecting a few drops of Pantopaque through the same unipolar electrode introduced through the stereotactic apparatus.

The target, more recently, has been located within the ventrolateral nucleus of the thalamus. A lesion measuring from 3 to 5 mm. in diameter is produced. A large lesion is not necessarily more effective.

Successful surgery is predicated on the precise localization of the lesion. The larger the lesion, the greater the chance of postoperative complica-

tion. Long term (seven to eight year) benefits have accrued to 75% of the parkinsonian patients in this series.

Report of Cases

To illustrate "permanent" (seven to eight years) relief of rigidity and/or tremor by surgical intervention in parkinsonism, the following case reports are appended:

Case 1.—A 62 year old, right-handed man with bilateral parkinsonism was first examined on Jan. 15, 1957. His first symptom began 10 years earlier as pain, due to rigidity, in the right shoulder and arm followed by tremor and rigidity that gradually involved the right leg. By the time he was seen, tremor of the right-sided extremities was severe. Rigidity was moderate. He had the typical masklike expression of parkinsonism and loss of associated movements. In July 1957 a pallidotomy was performed on the left side by the Fairman stereotactic technique with an immediately satisfactory result revealed by marked diminution of tremor and rigidity. This patient has been examined every six months. Progressive improvement has been noticed, not only of the hyperkinetic symptoms, but also in his attitude and general health. It should be pointed out that complete suppression of tremor and rigidity was not achieved until after two years had elapsed following the operation. The last examination of this patient was performed in September 1965. Relief of symptoms has persisted for eight years. The right-sided extremities were completely still and no rigidity could be detected. No tremor could be detected even under emotional stress.

Case 2.—A 47 year old, right-handed schoolteacher with a history of rigidity and tremor involving the right-sided extremities for approximately nine years, was examined in March 1958. The first symptom she noticed was stiffness of the right arm which was noted when she tried to cut her food or write. Tremor appeared later, but rigidity was always the predominant symptom. An important problem was the fact that she was very sensitive to practically all antiparkinsonian analgesic drugs. In spite of the fact, therefore, that the symptoms were only unilateral, she stopped going to school because she was unable to perform her duties and could not even do housework. She performed the activities of daily living with great effort. A pallidotomy was performed on the left side in December 1958 by the Fairman stereotactic technique. The immediate postoperative result was excellent with practically complete abolition of the hyperkinetic symptoms and the rigidity. Six months after the operation she returned to work as a teacher and has performed the activities of daily living with no difficulty. Her last examination in September 1965, seven years after the operation, revealed that beneficial results have persisted.

Discussion

The first patient is an example of that group of parkinsonian patients in whom the hyperkinetic manifestation of tremor is predominant. Patients are frequently self conscious and try to conceal the tremor. They are frequently under emotional stress. Events of daily life frequently upset them, making the tremor more apparent. In their efforts to conceal the tremor they become

more nervous. By abolishing or suppressing the tremor a complete psychological rehabilitation of these patients can often be achieved.

The second patient is an example of that group of parkinsonian patients in whom rigidity is the predominant symptom with marked impairment of function.

It is believed that good and lasting results depend mainly on the following criteria:

(1) Surgery is effective only to control hyperkinetic and hypertonic symptoms. Disability caused by marked akinesia, pseudobulbar palsy, autonomic dysfunction or emotional imbalance is not influenced by surgery of the subcortical motor systems. Such patients should be rejected as unfit candidates for surgery. Patients in whom intracerebral abnormalities are noted at the time of pneumoencephalography should be considered very carefully as to their suitability for stereotactic approach to the subcortical structures since distortion of the intracerebral structures may be so marked that an accurate placement of the lesion is difficult, if not impossible.

(2) The ultimate duration of control of disability for dyskinesias depends on the accurate positioning of the lesion. It should be large enough to be effective, yet not cause neurological, emotional or intellectual deficit.

Summary

The aim of surgery in the treatment of parkinsonism is to rehabilitate the patient by relieving rigidity and/or tremor. The duration of benefits from surgery in parkinsonism is discussed based on experience with 265 patients operated on by us since 1957. Long term beneficial effects depend upon the correct selection of patients and the accurate placement of the lesion.

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Screen Tests For Metabolic Disorders In Newborn Infants

CHARLES H. CARTER, M.D.

Several of the states have recently passed laws making mandatory certain tests on newborn infants for certain hereditary metabolic disorders. Florida legislators seriously considered this law in the last legislature, but were persuaded to postpone the mandatory part in deference to a trial period of voluntary testing. In this action there was an implied warning to the medical profession that if voluntary testing was not satisfactory, legislative action would be taken. This, naturally, means greater infringement of government upon the private practice of medicine, and greater regulation of the activities of the physician, and could easily serve as a stepping stone to further restriction of private practice. The pitfalls and fallacies of such a legislative approach to testing are obvious; therefore, it behooves the medical profession to do everything it can to prevent this approach.

The following is a brief discussion of types of testing that are available and that can be done in most cases as screening procedures—several that should be done regardless of the family history and others that should be done in cases of positive family history. Other tests are being developed at frequent intervals and should be added to this list. It should also be emphasized that specific tests are constantly being improved;

therefore, legislative action requiring certain specific tests would be very detrimental. Some states have already made this error. Various conditions for which the tests are better known are listed and a brief word said about many.

Phenylketonuria

The first screening test advocated for phenylketonuria was the ferric chloride test of the urine and later Phenistix were advised. Neither of these tests is satisfactory since they do not detect urinary abnormalities until the blood levels are relatively high. In some cases the patient may receive brain damage without the urine test ever becoming positive. Certain surveys have suggested only one third to one half of the positive cases will be detected by urine tests.

See editorial, page 1201

Blood tests for phenylketonuria include the Guthrie test, which is an inhibition of growth of *Bacillus subtilis* by phenylalanine, phenylpyruvic acid and phenylacetic acid in the blood. This test is done with a filter paper spot of blood. Occasionally a false positive is seen but this is relatively rare. The enzymatic spectrophotometric method of La Du, using snake venom, has been used as a confirmatory test. The spectrofluorometric method of McCaman and Robbins is relatively rapid and is accurate. Paper chromatic methods,

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Read before the Florida Medical Association, Ninety-Second Annual Meeting, Hollywood, May 13, 1966.

particularly bi-directional migration, are not particularly suited to mass screening, but are a good detection test.

A positive test by any of these methods should be confirmed by serum phenylalanine levels, and if there is any question concerning the diagnosis, the phenylalanine loading test should be utilized. Early treatment is necessary to prevent mental retardation.

The use of these tests before the patient has received protein feedings for at least 48 hours, however, will lead to false negatives in many cases. It is advisable that one of these tests be done approximately 48 hours after feeding is started and repeated again at three to six weeks of age.

Other conditions for which tests are available, some of which can be adapted to screening techniques, are included in table 2.

Table 1. — Inborn Errors of Metabolism Characterized by Elevated Blood Amino Acids

DISEASE	AMINO ACID ACCUMULATED IN BLOOD	CHIEF CLINICAL FEATURES IN PATIENTS WITH BIOCHEMICAL DEFECT	SOURCE OF DATA
Phenylketonuria	Phenylalanine	Mental retardation Convulsions Eczema Fair hair and skin	Knox Jervis et al.
Maple syrup urine disease	Valine Leucine Isoleucine	Mental retardation Spasticity Myoclonic seizures	Dancis et al.
Tyrosinosis	Tyrosine	Myasthenia gravis	Medes
Hyperprolinemia	Proline	Congenital genito-urinary tract anomalies Renal disease Photogenic epilepsy Mental retardation	Schafer et al.
Hydroxyprolinemia	Hydroxyproline	Mental retardation Microscopic hematuria	Efron et al.
Histidinemia	Histidine	Delayed speech development Mental retardation	Ghadimi et al. La Du et al.
Citrullinuria	Citrulline	Mental retardation Convulsions Vomiting	McMurray et al.
Hyperglycinemia	Glycine	Mental retardation Ketosis after leucine ingestion Neutropenia and thrombocytopenia Hypogammaglobulinemia	Childs et al.
Homocystinuria	Methionine (Homocystine in urine)	Mental retardation Seizures Dislocated lenses Thromboembolic phenomena	Carson et al. Waisman et al.
Oasthouse urine disease	Valine Leucine	Mental retardation White hair	Smith and Strang

Maple Syrup Urine Disease

Maple syrup urine disease is caused by a failure of metabolism of the branch chain amino acids, particularly leucine, isoleucine, and valine. This condition is not seen as frequently as phenylketonuria but should be suspected in any case presenting a positive family history, or in which the urine has a maple syrup odor. Bacterial inhibition tests similar to the Guthrie test for phenylketonuria have been developed in that the

2-methyl leucine inhibits the growth of *Bacillus subtilis*. This inhibition is prevented by the presence of leucine, isoleucine or valine.

The condition is detectable by paper chromatographic methods 48 hours after feeding is started. It should be remembered that chromatographic separation of urine and serum in the newborn is still in its early stages; therefore, much is not known concerning early amino acid metabolism. If diet is regulated accurately, many of these children can be normal.

Table 2. — Available Tests

Syphilis	One of the well known accepted tests
Gargoylism	Tests for chondroitin in the urine, such as the filter paperspot tests or thymal turbidity methods
Homocystinuria	Sodium cyanide nitroprusside reagent
Toxoplasmosis	Some of the skin tests or antibody titer studies
Chromosomal abnormalities	Dermal patterns
Klinefelter's syndrome and other sex abnormalities	Buccal smear
Nyhan's disease or familial infantile hyperuricemia	Blood uric acid
Hemolytic disease of the newborn	Prenatal Rh antibody titers Postnatal serum bilirubin or nucleated red blood cells
Hepatolenticular degeneration or Wilson's disease	Ceruloplasmin screening tests
Porphyria	Colorimetric and fluorometric examination of the urinary pigments
Metachromatic leukodystrophy	Urine tests for metachromatic granules
Spontaneous hypoglycemia	Glucose tests and blood sugar response to adrenalin
Gaucher's disease	Gaucher cells in the bone marrow
Niemann-Pick disease	Bone marrow examination showing "foam" cells
Dominance patterns (After four years of age)	Observation of hand, foot, eye, and ear dominance
Miscellaneous inborn errors of metabolism	Elevated blood amino acids

In addition to those mentioned, this list would include tyrosinosis, hyperproteinemia, hydroxyprolinemia, citrullinuria, hyperglycinemia, Oasthouse disease and hypothyroidism.

Histidinemia

Histidinemia is characterized by an excessive accumulation of histidine in the blood and urine. No treatment is available for this condition. It can be detected, however, by bacterial inhibition assay of *Bacillus subtilis* by azaserine, by paper chromatography and by the enzymatic electrophotometric method of La Du. This condition becomes apparent after the third day of protein feeding.

Galactosemia

Galactosemia is the inability to metabolize galactose to glucose. Mental retardation can be prevented by early detection and the administration of a galactose-free diet.

This condition can be detected by urine tests showing the presence of reducing sugars but the absence of glucose in the urine. The urine should be first tested for all reducing substances and the second test made for glucose only. The test for

Table 3. — Screening Tests for Mental Retardation

DISEASE	TEST
Phenylketonuria	Guthrie Blood levels of phenylalanine Phenylpyruvic acid—Phenistix
Maple syrup urine disease	Odor of urine Paper chromatography of urine for specific amino acids
H disease	Aminoaciduria
Galactosemia	Reducing substance in urine found by routine tests Substance proves to be galactose Blood levels of galactose
Acute porphyria	Colorimetric and fluorimetric examinations of urinary pigments
Gargoylism	Tests for chondroitin in urine 1. Paper chromatography 2. Rapid screening
Idiopathic spontaneous hypoglycemia	Glucose tolerance Blood sugar response to adrenaline
Metachromatic leukodystrophy	Urine test for metachromatic granules
Syphilis—congenital	Blood and spinal fluid tests
Toxoplasmosis—congenital	Skin test for sensitivity
Sex abnormalities (chromosomal)	Buccal smears
Hepatolenticular degeneration	Ceruloplasmin screening test
Hemolytic diseases of the newborn	Prenatal—Rh antibody titers Postnatal—Nucleated red blood cells Serum bilirubin
Serum amino-acid abnormalities (general)	Paper chromatography
Dominance (after four years of age)	Hereditary pattern Observation of the use of hand, foot, eye, and ear
Homocystinuria	Urine tested with sodium cyanide nitroprusside reagent
Gaucher's disease	Gaucher cells in bone marrow
Niemann-Pick disease	"Foam" cells in bone marrow
Hyperuricemia	Blood uric acid
Klinefelter's syndrome	Buccal smear test
Chromosomal abnormalities	Dermal patterns
Hypothyroidism	Ankle jerks

total reducing substances will be positive and the test for true glucose will be negative. Hereditary fructose intolerance will give a false positive here as well as pentosuria.

Galactose in the urine can be detected by paper chromatography and in the blood by the agar diffusion assay method using *E. coli* Strain WA 3101 which, being galactose-sensitive, will be positive.

The best method of either screening test is assay of cord blood for galactose-1-phosphate uridyl transferase. Severe anemia and glucose-6-phosphate dehydrogenase deficiency may give false positives in this test.

Discussion

It is most important that the physician take the initiative in doing certain of the screening tests listed (table 2), particularly those recommended by the American Academy of Pediatrics,

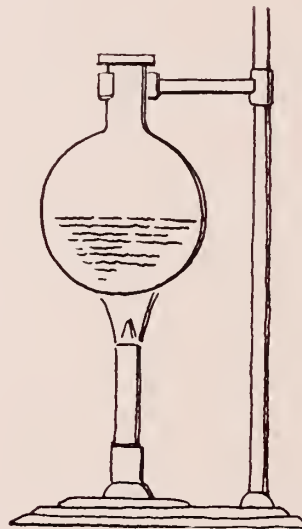
which would now include tests for phenylketonuria and galactosemia. It has also been recommended that large scale testing research-oriented screening programs be undertaken in regard to maple syrup urine disease, aminoacidurias in general, hepatolenticular degeneration, sex abnormalities and chromosomal abnormalities. As other tests and other methods of treatment become available in the future, they should be included.

Conclusion

It must be emphasized that if the physician fails his responsibility, the government will impose it upon him. It also should be emphasized that judgments already have been rendered in malpractice suits regarding phenylketonuria and hemolytic disease of the newborn. This consideration would make procedures of testing even more imperative to the physician.

References are available from the author upon request.

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President's Page



Hope

This is the month of the birth of Christ and it reminds us that God sent His Son to redeem men and offer the eternal hope of everlasting life. I always look forward to this time of year and its reminder of the significant event of Christmas.

We should all reflect on three virtues which, if possessed and practiced by any man, make him more like his Creator. They are Faith, Hope and Charity.

Faith in a Supreme Being is necessary in order to try to understand and properly hold in awe and perspective this world, this universe, and those things which God has enabled us to do and accomplish for the good of mankind.

Hope is essential so that we can look forward to each new day, to better things, a future and a better life.

Charity should be a natural force in each of us—to give of ourselves and thereby do good for others. I do not believe that one can be a complete physician without these three virtues.

I wish for you and yours a Joyous and Blessed Christmas. Let us not forget to count our blessings.

*Blessed be the man that provideth for the sick and needy:
the Lord shall deliver him in the time of trouble.*

Psalm XLI 1.

George S. Palmer

WHEN
THE BACTERIAL U.R.I.
SETTLES
IN HER SINUSES



ACHROCIDIN®

Tetracycline HCl-Antihistamine-Analgesic Compound

Each tablet contains:

ACHROMYCIN® Tetracycline HCl 125 mg
Phenacetin 120 mg

Caffeine 30 mg
Salicylamide 150 mg
Chlorothien Citrate 25 mg

The patient can feel better while getting better. ACHROCIDIN brings the treatment together in a single prescription—prompt symptomatic relief together with early, potent control of the tetracycline-sensitive organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

Effective in controlling complicating tetracycline-sensitive bacterial infection and providing symptomatic relief in allergic diseases of the upper respiratory tract.

Contraindication—History of hypersensitivity to tetracycline.

Warning—If renal impairment exists, even usual doses may lead to liver toxicity. Under such conditions, lower than usual doses are indicated and if therapy is prolonged, tetracycline serum level determination may be advisable. Hypersensitive individuals may develop a photodynamic reaction to natural or artificial sunlight during use. Individuals with a history of photosensitivity reactions should avoid direct exposure while under treatment and treatment should be discontinued at first evidence of skin discomfort.

Precautions—Some individuals may experience drowsiness, anorexia, and slight gastric distress. If excessive drowsiness occurs, it may be necessary to increase the interval between doses. Persons on full dosage should not operate any vehicle. Use may result in overgrowth of nonsusceptible organisms. If infections appear during therapy, appropriate measures should be taken. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Infections caused by beta-hemolytic streptococci should be treated for at least 10 full days to help prevent rheumatic fever or acute glomerulonephritis. Use of tetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect has been observed in usual short treatment courses.

Average adult dosage: 2 tablets four times daily, given at least one hour before, or two hours after meals.

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"To Let Them Know They Can Trust Me . . ."

Once upon a time there was a man who believed not in religion or in Christmas. Oh, he was a nice person, gentle, kind, trustworthy and up-standing in his community. By no means was he a Scrooge. He just lived a "decent" life, toed the mark which the community expected of him and was known for kindness and moderation in a typical community situation.

That which really bothered him about religion was the Doctrine of Incarnation. The idea that one person, born in one locality and in one particular time in history, could be the embodiment and in-the-flesh presentation of God to the world was beyond his comprehension. But an ordinary situation struck this man one Christmas eve which brought home the message and meaning of the Incarnation in such a way that a new and living Force was brought into his life. It happened as follows:

Christmas eve had arrived. The wife and children were getting ready to attend the Mass which bears the name of Christ and from which our Christ-mass season gets its name. He was asked, as in many Christmases past, to accompany the family to Church, but excused himself with the explanation that he would feel too much like a hypocrite (that means "play actor" in the Bible—a most apt description). He would rather stay home and wait up for them to return.

Shortly after the family drove away from the house, the soft and gentle snow of a Northern

Christmas began to fall upon the area. The man went to the window and watched the flurries getting more severe as time passed. Having had his fill of the winter scene, the man settled back into his comfortable chair by the fire to spend the Christ-Mass eve by reading.

But a curious thing happened. He was startled by a thudding noise outside the house. This was followed by another and then another. It sounded like someone throwing snowballs. Of course he got up, went to the door, and investigated the scene. There, caught in the storm, was a flock of birds, grounded by the storm and desperately searching through closed windows for shelter on the other side.

This scene touched the man, making him want to do something for the helpless creatures. Perhaps he could put on his coat, come out again, and lead them to the barn out back where they would be safe from the storm. So, returning from the house moments later in more suitable attire, he tried his plan. First he opened the barn door to let the birds in, but they just hovered near the house, afraid and cautious. Then he turned on a light inside the barn. They still made no move, even though he had illuminated the scene to make it more inviting to them. He then hurried to the house, brought out some bread crumbs and scattered them in the doorway of the barn, trying to entice the nearly frozen birds with food. But, to his dismay, the birds still ignored the bread

crumbs and continued to flop around aimlessly and helplessly in the snow. Then he tried, as a last resort, to shoo them in. Still they would have none of it.

"They find me a strange and terrifying creature," he said to himself, "and I can't seem to think of any way to let them know they can trust me. If only I could be one of them for a few moments so they could see the truth, follow me, and find shelter."

Then it hit him. Of course! Incarnation—in the flesh—in this mystery God had solved His problem with mankind. He had become one of us to lead and to provide. In this way God let man know, through another man and not a strange and terrifying creature, that we can trust Him. Here is the mystery, joy, discovery and Godliness of Christmastide. "God so loved the world that He gave His only begotten Son to the end that all who believe in Him (trust Him, serve Him, seek after Him, and depend upon Him) should not perish but have everlasting Life."

This illustration has been told by the UPI religious editor, Louis Cassels, about what Christmas means to the Christian. But what about this babe born in a dirty stable who grew to manhood, ministered for about three years in one confined little corner of the world, and died the death of a common criminal before his thirty-fourth birthday? One unknown writer put it concisely in these words about the Incarnate One:

"Here is a man who was born in an obscure village, the child of a peasant woman. He grew up in another village, and that a despised one. He worked in a carpenter shop for 30 years, and then for three years He was an itinerant preacher. He never owned a home. He never had a family. He never went to college. He never put his foot inside a really big city. He never traveled, except in His infancy, more than 200 miles from the place where He was born. He had no credentials but Himself.

"I am well within the mark when I say that all the armies that ever marched, all the navies that were ever built, all the parliaments that have ever sat and all the kings that have ever ruled put together have not affected the life of man upon this earth like this one solitary personality."

Two statements stand out: "He had no credentials but Himself" and "no one has affected the life of man upon this earth like this one solitary personality." What beautiful sentiments! And why? Because in that life God chose to reveal

His complete nature, plan and concern for mankind. Does it not necessarily follow and naturally follow, then, that Christmas is so much more than happy handshakes and that "warm feeling of goodness all around?" But how can the Incarnate One, sent to the world to let men know he can trust, truly, in God, actually come to have deeper reality for us today?

He had no meaning, of course, for many then, even as for many His meaning is obscured today. At that manger in Bethlehem you do not see the king, the emperor, or the governor. They were too busy. You do not see many of the "religious" people of the day, either. Perhaps they were satisfied with things as they were. You do not see the "religiosity-minded" either, because they already were too absorbed in other things. No, you do not even see the irreligious. They simply couldn't be bothered.

But if you look at the personalities who were at the manger that night, I believe God gives us a clue to what it takes to appreciate Him more. Look, then, for a moment at the shepherds, the learned ones, and the holy family.

A good descriptive word for the shepherds is trust. They know and are known of their own. They are trusted, followed and obeyed. The sheep trust their shepherds, follow them, and will follow no other than their own. Trust is one of the key words, then, for people who would find strength in our times through the Incarnate One. That means real trust, not any superficial substitute.

And what describes the Wise Men? I think the word best fitting these Doctors is searching. They practiced their craft, never being content with partial answers. Theirs was an art for the benefit of mankind. Here were the scientists who were willing and driven to explore, search and seek. These people, too, found Life in a newer form at that first Christmas.

Faith is the word which perhaps best fits Mary and Joseph. By faith they accepted the miraculous event. By faith they made the long and hard journey as beckoned by the authorities. By faith they awaited the unheard-of miracle which God would bring about through them, for God did indeed choose them to believe, to do, and to be something never before known in the history of man.

Not everyone saw the Incarnate One many centuries ago, for not many cared. But those who did care showed it through an attitude of trust, searching and faith. It has ever been so. Here,

then, are three qualities necessary for those who would have the Living Christ come more and more into their life. First, a belief that really trusts in the Ultimate; then searching which constantly looks for more knowledge, experience and service of Him; and a faith which knows from where it has come, to where it is going, and to Whom it is committed.

In Christmastide, 1966, we are reminded once again of what the season is all about in the eyes of God, who wants the world to see, through Christ, and to know it can trust Him. We are reminded, too, of the tremendous impact which one Life has had and continues to have on the world. Finally, we are reminded that trusting,

searching and true faith are the classic and basic clues by which the world is found in Him. These are the facts.

The question now is: "If God did all this to let the world know it could trust Him, where and how does the response begin in me?"

THE REVEREND DONIS D. PATTERSON, RECTOR
SAINT MARK'S EPISCOPAL CHURCH
VENICE

Editor's Note: The Reverend Fr. Patterson is Director, Saint Mark's Parish Day School, Venice; Chairman, Division of Evangelism, Episcopal Diocese of South Florida, and Chaplain (Major) United States Army Reserve.

This is the Sixth in a series of invited guest editorials appropriate to the season by leading ministers and rabbis published in the hope that physicians will find these messages a source of guidance and inspiration.

Good Old Doc Is Dead

"There are men and classes of men that stand above the common herd," wrote Robert Louis Stevenson of the physician less than a century ago. Yet medicine's public image was never more jaundiced than it is today, and it is not likely to improve unless doctors start paying at least as much attention to how the public sees them as they do to the Wednesday afternoon golf game. Writing in the Sunday New York Times, for October 16, under the title "The Doctor's Image is Sickly," Walter Goodman—who is sympathetic toward the medical profession—gives a penetrating and cogent analysis of the ailing image of the physician today. Much less charitable is the veritable avalanche of articles and books pouring from the presses almost weekly with titles like "The Doctor Business," "The Troubled Calling," "The Doctors' Dilemmas," and "American Medical Avarice." Most vicious of all is a slashing attack on medicine in general, "The Doctors" by Martin L. Gross (Random House).

"The Doctors" is a particularly effective broadside because again and again the author quotes from medical writings to support such statements as: "The surgically opened body appears to be a veritable magnet for foreign objects,"

"Error, even extravagant error, appears to be part of the natural order of surgery in the modern hospital," "the morass of modern medical educational chaos," "the exquisite non-planning of American medicine," "trade school mentality" and the like. By lifting statements out of context, he manages to have the doctors of today effectively damn themselves out of their own mouths.

The end of the year is the traditional time for soul-searching. But looking at American medicine, today's doctor, and the rapidly deteriorating patient-doctor relationship of trust and even affection that once existed, one can hardly fail to conclude that the soul-searching should have been done a long time ago—as this writer has repeatedly pointed out in these pages. In some 20 years since the end of World War II, the image of the doctor in the eyes of the people has shrunk more than in the twenty-odd thousand years since the first physician was portrayed in the cave paintings of primitive man. While making scientific progress unequaled in all of history, the organized medical profession has fought a stubborn rear guard action against significant socioeconomic reform, social security, group practice, to name but a few—and lost every battle. And at

a time when hospitals are forced to beg for graduates of foreign medical schools or do without house staffs, no working partnership with government for an increased program of medical education to supply doctors badly needed in many areas has yet appeared.

Is it a wonder that "Good Old Doc" died some time ago in the eyes of much of the public? Even more sad, "Good New Doc," though far more efficient and scientifically skilled, hasn't been able to sell himself as a substitute, judging by the barrage of public criticism of the medical profession from all sides. In effect, then, private medical practice seems to be digging its own grave, for if the sick man cannot admire, even revere, his private doctor, he might as well have one furnished by the government—and probably will.

Why did Good Old Doc stop being a figure of reverence and start becoming a tradesman in the eyes of much of the public? Finding an answer to that question is puzzling not only physicians who are concerned about preserving our cultural heritage as a profession, but also friends in all walks of life. Certainly television had nothing to do with it for Ben Casey and Young Doctor Kildare built a far better image of the doctor in the public mind than most physicians do. The medical heroes of TV were idealistic, dedicated and unselfish, qualities whose lack in the young

doctors of today writer after writer is deploring in the public press.

When medicine ceases to be a calling toward which young men are drawn by motives of desire for service and the satisfaction that service brings, its death knell as a respected profession will have been sounded—and many believe the bell has already begun to toll. Much of the trouble undoubtedly lies in the increasing narrowness of medical education, narrowness which can only tend to produce highly trained technicians instead of broadly humanitarian physicians. A doctor whose medical world is limited to the visual field afforded through a proctoscope is not likely to be a broadly motivated individual, unless the traditional idealism of his calling is instilled into him while a student.

Yes, Good Old Doc is dead—and perhaps best buried along with his many inadequacies. But if Good New Doc is to retain any of the old codger's better qualities, he must be much more human in his approach to medicine as a calling and an art than most graduates of today's medical schools.

FRANK G. SLAUGHTER, M.D.
JACKSONVILLE

Editor's Note: This is the fourteenth consecutive year The Journal has published a guest editorial in December by Dr. Slaughter, Florida's distinguished physician-author.

Reporting on Your Patients for Social Security Benefits

In the state of Florida, the Division of Vocational Rehabilitation prepares disability determinations for the Social Security Administration under a state-federal agreement. The patient applies for disability benefits at his local social security office and the patient is responsible for obtaining a report from his personal physician at that time. The Social Security Administration then forwards reports from the treating physician as well as other nonmedical information to the state agency of vocational rehabilitation, where an evaluation team has the authority to make the de-

cision of disability. The evaluation team is composed of physicians as well as special counselors in vocational rehabilitation.

Physicians in vocational rehabilitation constitute the nucleus of the evaluation team from the medical viewpoint. They review the reports submitted by other physicians on behalf of their patients who are alleging disability and are applying for social security benefits. The reviewing physicians are either full-time or part-time. Many are also engaged in private practice. Their backgrounds include a wide range of specialties as well

as general practice. The physician who reviews the report looks at history, physical findings and supporting laboratory evidence.

The history is extremely important and should include onset, frequency of symptoms and current status. Specific data, such as the amount of effort required to produce symptoms, is needed. The physical examination should include general appearance, gait and specific and pertinent findings. Laboratory evidence that supports a clinical diagnosis is also required. The medical evidence should assist the reviewing physician in deciding the severity of the impairment and give an idea as to the prognosis and duration of the impairment. Objective evidence is more valuable than opinion statements and does not cause as much conflict in the cases evaluated.

The reviewing physician often telephones the treating physician to discuss the case, particularly if supplemental information is needed. This pro-

cedure should relieve the treating physician of additional paper work and frequently make it unnecessary to purchase a consultative examination.

All applicants for social security benefits are also considered for referral to the Division of Vocational Rehabilitation for services and job placement. Approximately 800 applicants for social security benefits in Florida were returned to gainful employment in this manner during the past year.

If further information is needed, please contact the Division of Vocational Rehabilitation, Disability Determination Section, Room 229, 725 South Bronough Street, Tallahassee, Florida.

FRED B. THIGPEN, M.D.
CHIEF MEDICAL CONSULTANT
DISABILITY DETERMINATION SECTION
DIVISION OF VOCATIONAL REHABILITATION
STATE DEPARTMENT OF EDUCATION
TALLAHASSEE

Door Leading to Another Door Galactosemia - One Disease?

Many disease entities at some time thought to be well defined are later found to be much more complicated on the basis of additional clinical and biochemical information. At the present time there appear to be at least two genetic factors which can be responsible for the decrease or absence of galactose-1-phosphate uridyl transferase activity in red cells. In "classical" galactosemia there is an almost complete absence of enzyme activity in the homozygote, and a 50% decrease of activity in the heterozygote. Last year Dr. Beutler¹ reported a new variant called "Duarte" which is characterized by the homozygote having a 50% level of the enzyme and the heterozygote having a 75% level. So far as I know, there is no evidence of mental retardation in this group of patients.

The irregular occurrence of mental retardation in "classical" galactosemia in another unexplained phenomenon. Approximately 25% to 30% of patients with "classical" galactosemia are mentally retarded and the rest are not.² There is a possibility that the patients with "classical" galac-

tosemia may segregate into two or more groups, some of whom are mentally retarded and some of whom are not, but all of whom are characterized by a decrease of transferase in the red cells.

See article page 1190

This finding is not unlike the present understanding of phenylketonuria. There now appear to be at least two types of phenylketonuria: a "severe" type with a high serum phenylalanine and severe mental retardation, and a second, "mild" type with only a moderate elevation of serum phenylalanine in which the incidence of mental retardation may be low or absent.³ This second type is being explored from several angles at the present time.

References are available from the author upon request.

DAVID YI-YUNG HSIA, M.D.
DEPARTMENT OF PEDIATRICS
UNIVERSITY OF CHICAGO
CHICAGO, ILLINOIS

against the usual gram-negative urinary pathogens

Why use five...where one will do?



In a recent 217-patient hospital study,¹ urinary tract infections were treated with a variety of widely prescribed antimicrobial agents including: a sulfonamide (40 patients), chloramphenicol (20 patients), nitrofurantoin (33 patients), nalidixic acid (30 patients), tetracycline (27 patients), colistimethate sodium (22 patients) ... and 2 combinations of 5 agents each (45 patients). The 2 combinations were selected to afford maximal theoretical antibacterial coverage against the usual urinary pathogens. They were (1) tetracycline, chloramphenicol, nitrofurantoin, rifstocetin and polymyxin B; and (2) tetracycline, chloramphenicol, erythromycin, nitrofurantoin and colistimethate sodium.

This clinical study shows that the two combinations of antibiotics were not superior to some of their single components. The authors point out that antibiotic antagonism often negates theoretical advantages of multiple therapy. Coly-Mycin Injectable (colistimethate sodium) was one of the single components that was shown to be equal to the combinations and eradicated bacteriuria in two-thirds of the patients.

Theoretical choice of multiple antibacterial therapy has been shown to be no more effective than one well-chosen agent which also offers least patient exposure to possible side reactions, toxicities, allergic manifestations and higher drug costs.

1. McCabe, W. R., and Jackson, G. G.: *New England J. Med.* 272:1037, 1965.

in gram-negative urinary tract infections often the single well-chosen agent



Coly-Mycin® Injectible

(colistimethate sodium)

Indications: Especially indicated for the treatment of severe acute and resistant chronic urinary tract infections due to sensitive strains of gram-negative organisms. Also indicated in respiratory tract, surgical, wound and burn infections and in septicemia due to sensitive organisms. Particularly indicated when any of these infections are caused by sensitive strains of *Pseudomonas aeruginosa*.

Adverse Reactions: Occasional reactions such as circumoral paresthesias, tingling of the extremities, pruritus, vertigo or dizziness may occur. Reduction of dosage may alleviate symptoms. Therapy need not be discontinued, but such patients should be observed with extra care.

Warning: Patients should be cautioned not to drive vehicles or use hazardous machinery while on therapy.

Precautions: In cases of impaired or suspected renal impairment, use with greater caution and reduce dosage in proportion to extent of impairment. Transient elevations of BUN have been reported. As a routine precaution, appropriate blood studies should, therefore, be made during prolonged therapy.

As with all polypeptides, the possibility of muscular weakness, including apnea, due to inadvertent overdosage or normal dosage in the presence of impaired renal function, should not be overlooked. In cases of apnea, medication should be promptly discontinued and assisted respiration given until serum levels fall and normal breathing is restored.

Other antibiotics, such as kanamycin, streptomycin, dihydrostreptomycin, polymyxin, and neomycin, may also have varying neurotoxic or nephrotoxic potential. They should be used with great caution concomitantly with Coly-Mycin Injectible (colistimethate sodium).

For deep intramuscular injection only.

Dosage: By the I.M. route only, in 2 to 4 divided doses ranging from 1.5 to 5 mg./Kg./day (0.7 mg. to 2.3 mg./lb./day). Average adult dose is 2.5 mg./Kg./day (1.1 mg./lb./day). In the presence of bacteremia, septicemia, or other serious infection, greater than average doses may be required; however, maximum daily doses should not exceed 5 mg./Kg. (2.3 mg./lb.) where renal function is normal.

Not recommended against *Proteus*.

Colistin is also available (as colistin sulfate) in: Coly-Mycin® Pediatric for Oral Suspension (not for systemic use), and Coly-Mycin® Otic with Neomycin and Hydrocortisone.

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DIUTENSEN-R is thiazide and reserpine *plus* cryptenamine — a rational, comprehensive therapy to help establish and maintain early, more decisive control of blood pressure.

The cryptenamine in DIUTENSEN-R helps improve normal vasodilating reflexes while the thiazide and reserpine components maintain vasorelaxant, sedative, and saluretic benefits. Cryptenamine lowers pressoreceptor reflex thresholds (which may be abnormally high in hypertension) — “resets” pressoreceptors to function at more nearly normotensive levels.

Early, more decisive control with DIUTENSEN-R helps secure continuing benefits — may reduce or even obviate the need for poorly tolerated drugs later in therapy.

“... quite apart from the problem of vascular damage, there arises a possibility of virtual ‘cure’ or remission of hypertension when treatment is early, i.e., before too many other secondary pressor systems have entered into the disequilibrium of pressor control, and when it is adequately suppressive.”

Corcoran, A. C.: The choice of drugs in the treatment of hypertension. In: *Drugs of Choice* 1966-67, W. Modell, Ed., St. Louis, C. V. Mosby Company, 1966, p. 417.

Indications: DIUTENSEN-R may be employed in all grades of essential hypertension.

Dosages: Usual dose is 1 tablet twice daily, at morning and evening meals.

However, adjustment of dosage to suit individual circumstances may be required. Please refer to package insert for full particulars. **Side effects and**

precautions: The side effects observed with patients on DIUTENSEN-R have been of a mild and nonlimiting nature. These include occasional urinary frequency, nocturia, nasal congestion, muscle cramps, skin rash, joint pains due to gout symptoms and nausea and dizziness which have been reported for the individual components. Most of these symptoms disappear while the drug is continued at the same or lower dosage level. The concomitant use of digitalis and DIUTENSEN-R may increase the possibility of digitalis-like intoxication. If there is evidence of myocardial irritability (extrasystoles, bigeminy or AV block), dosage of DIUTENSEN-R should be reduced or discontinued. Nocturia in patients with marginal cardiac status and salt and fluid retention can be effectively controlled by limiting the time of administration to early afternoon.

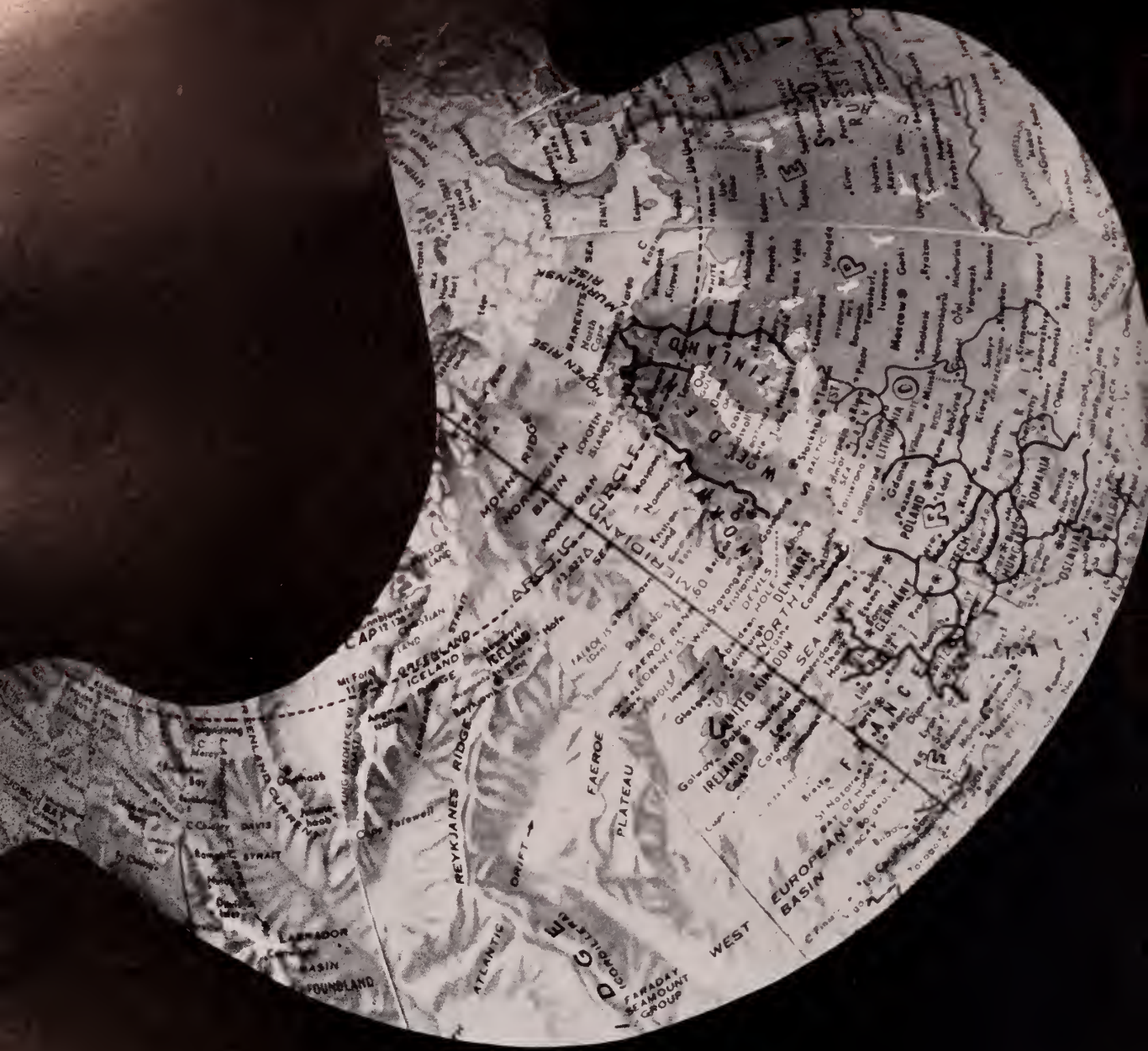
DIUTENSEN-R should not be used in patients with a known intolerance to reserpine. Package inserts furnish a complete summary of recommended cautions related to each of the ingredients of DIUTENSEN-R.

*As tannate salts equivalent to 130 Carotid Sinus Reflex Units.

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The “Socio- geographic” mystery

Why is one man's gastric ulcer another man's duodenal?



Geographic variation in the *incidence* of peptic ulcer is a familiar fact. But the proclivity of certain *kinds* of ulcer for certain geographic areas is a recently recognized phenomenon.^{1,2}

For example, in one particular Norwegian fishing village there is a tendency for patients to develop a gastric ulcer; anywhere else in Norway, ulcers are usually duodenal. Peruvians high in the Andes have more gastric ulcers than their compatriots in the lowlands. Why? Nobody knows.

Social variations, too. Even in the same geographic areas there are interesting variations. An Englishman's ulcer depends on his social standing—professional men suffer with duodenal ulcers, while workingmen have more of the gastric variety. In southern India the pattern is reversed. Here, duodenal ulcers are common among laborers and agricultural workers and rare among the upper classes.

Investigators are exploring every possible theoretical avenue in their search for the cause of peptic ulcer. Of all the factors implicated in ulcerogenesis, the one that is generally acknowledged to be of primary importance is hypersecretion of gastric acid.³⁻⁸ Or, as one author states it: "The medical management of peptic ulcer pharmacologically is, in the final analysis, concerned largely with the effective inhibition of peptic activity."³

Robinul (glycopyrrolate) provides potent, rapid, specific antisecretory action as confirmed by gastric analyses and x-ray evidence of clinical effectiveness.^{3,7,9-12} It relieves pain with "impressive" promptness.⁸ Quickly alleviates acute discomfort, effectively counteracts gnawing pain, preprandial midepigastric pain, burning and other ulcer symptoms.⁷ Suppression of nocturnal pain is "outstanding."¹³ Maximally effective doses may be given with minimal side effects, and the incidence of unwanted anticholinergic effects is negligible.^{3,7-14}

No matter what the ulcer theory...the fact is that

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(brief summary follows)

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**promotes the
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environment**

Indications: In addition to its primary indications for duodenal and gastric ulcer, Robinul (glycopyrrolate) is indicated for other GI conditions that may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.

Contraindications: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.

Precautions: Administer with caution in the presence of incipient glaucoma.

Adverse Reactions: Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

Dosage: Dosage should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet 3 times a day: in the a.m., early p.m., and at bedtime. *See product literature for full prescribing information.*

Supply: Robinul (glycopyrrolate 1 mg.); Robinul Forte (glycopyrrolate 2 mg.); Robinul-PH (glycopyrrolate 1 mg.) with phenobarbital 16.2 mg. (Warning: May be habit-forming); Robinul-PH Forte (glycopyrrolate 2 mg.) with phenobarbital 16.2 mg. (Warning: May be habit-forming.) In bottles of 100 and 500 scored tablets.

References: 1. Jones, F. A., and Gummer, J. W. P.: Clinical gastroenterology, Springfield, Ill., Charles C Thomas, 1960, pp. 322-3. 2. Bockus, H. L.: Gastroenterology, 2nd ed., vol. I, Philadelphia, Saunders, 1963, p. 468. 3. Sun, D. C. H.: Ann NY Acad Sci 99:153 (Feb. 28) 1962. 4. Moore, V. A.: Postgrad Med 38:216 (Sept.) 1965. 5. Dragstedt, L. R., Woodward, E. R., Storer, E. H., Oberhelman, H. A., Jr., and Smith, C. A.: Ann Surg 132:626 (Oct.) 1950. 6. Posey, E. L., Jr., Smith, P., Turner, C., and Aldridge, J.: Amer J Dig Dis 10:399 (May) 1965. 7. Lamphier, T. A., Siegel, L., and Goldberg, R. I.: Amer J Gastroent 37:551 (May) 1962. 8. Kasich, A. M., and Fein, H. D.: Ibid 39:61 (Jan.) 1963. 9. Epstein, J. H.: Ibid 37:295 (Mar.) 1962. 10. Moeller, H. C.: Ann NY Acad Sci 99:158 (Feb. 28) 1962. 11. Slinger, A.: J New Drugs 2:215 (Jul.-Aug.) 1962. 12. Barman, M. L., and Larson, R. K.: Amer J Med Sci 246:325 (Sept.) 1963. 13. Shutkin, M. W.: Amer J Gastroent 38:682 (Dec.) 1962. 14. Flesher, B.: J New Drugs 2:211 (Jul.-Aug.) 1962. **A. H. ROBINS CO., INC.**
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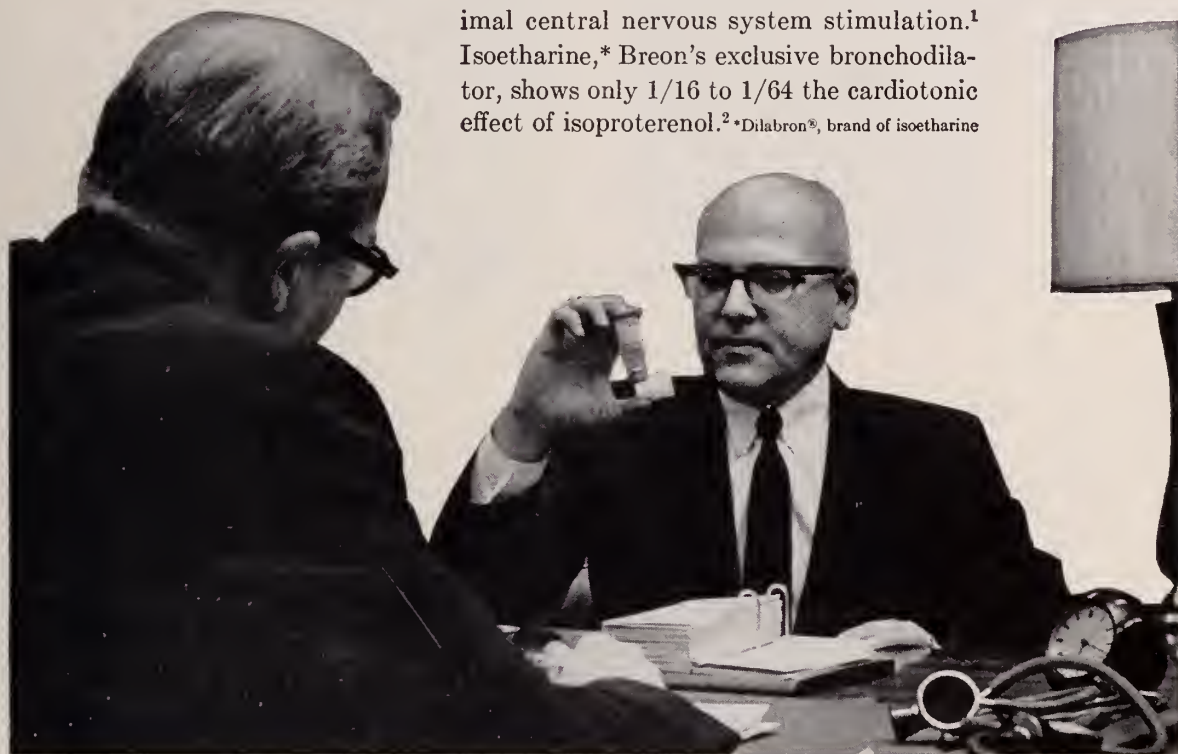
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"I like Bronkometer... I breathe better... don't get the jitters."

Patients feel relaxed with Bronkometer. Its bronchodilator-decongestant action has minimal central nervous system stimulation.¹ Isoetharine,* Breon's exclusive bronchodilator, shows only 1/16 to 1/64 the cardiotoxic effect of isoproterenol.² *Dilabron®, brand of isoetharine



BRONKOMETER[®] ASTHMA, CHRONIC BRONCHITIS, EMPHYSEMA

isoetharine 0.6%; phenylephrine 0.125%; thenyldiamine 0.05%—Superior because it contains isoetharine

COMPOSITION: Bronkometer delivers at the mouthpiece 200 metered doses of: 350 mcg isoetharine methanesulfonate (0.6%); 70 mcg phenylephrine HCl (0.125%); and 30 mcg thenyldiamine HCl (0.05%) with saccharin, menthol and fluorochlorohydrocarbons as inert propellants. Preserved with ascorbic acid 0.1% and alcohol 30%.

RECOMMENDED DOSAGE: One or two inhalations with at least one minute between inhalations. Occasionally more may be required, however in most cases, inhalations need not be repeated more than every four hours. Dosage should be adjusted to the severity of the condition and to patient's response.

PRECAUTIONS: Bronkometer is unusually free from cardiovascular and other side effects, but the usual precautions associated with sympathomimetic amines should be observed. Bronkometer should not be administered simultaneously with epinephrine or similar compounds because of the possibility of tachycardia, although it may be alternated with these agents. Dosage must be carefully adjusted in patients with hyperthyroidism, hypertension, acute coronary disease, cardiac asthma, limited cardiac reserve and in individuals sensitive to sympathomimetic amines.

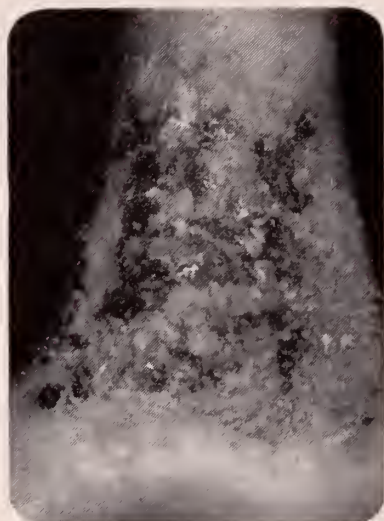
SUPPLIED: 10 ml pressurized aerosol vials complete with measured dose valve and oral nebulizer.

References: 1. Spielman, A. D.; *Curr. Therap. Res.* 3:235 (June) 1961. 2. Herschfus, J. A.; Bresnick, E.; Levinson, L.; and Segal, M. S.; *Ann. Allergy* 9:769 (Nov.-Dec.) 1951.



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Eczema of many years... controlled in two weeks



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*After treatment —
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Ointment 0.1% for two weeks*

ARISTOCORT® Triamcinolone Acetonide Topicals have proved exceptionally effective in the control of various forms of eczema: allergic, atopic, nummular, psoriatic, and mycotic.

In most cases responsive to topical ARISTOCORT, the 0.1% concentration is sufficiently potent. The 0.5% concentration provides enhanced topical activity for patients requiring additional potency for proper relief.

Administration and Dosage: Apply sparingly to the affected area 3 or 4 times daily. Some cases of psoriasis may be more effectively treated if the 0.1% Cream or Ointment is applied under an occlusive dressing.

Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side

effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive non-permeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyoderma will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

Available in 5 Gm. and 15 Gm. tubes and ½ lb. jars.

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Topical Ointment 0.1% and Cream 0.1%, 0.5%
Triamcinolone Acetonide

Also available in foam form.



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406-G

"Tranquilizer' is not a good word"¹

THIS classification is psychologically too seductive, pharmacologically too unspecific, and in terms of results not infrequently untrue."²

What is a tranquilizer? According to the 24th Edition of Dorland's Medical Dictionary³ a tranquilizer is "an agent which acts on the emotional state, quieting or calming the patient without affecting clarity of consciousness."

Defining a drug by its effects, however, can be misleading. The same effects by which the dictionary defines a tranquilizer have sometimes been seen after administration of a sedative — or, for that matter, a placebo.

Ambiguous though the term may be, it appears to be here to stay. The 1966 edition of the Physicians' Desk Reference⁴ lists 42 tranquilizers indicated for treatment of anxiety and apprehensive states.

'Tranquilizers' have differences in action, differences in effect

Although all tranquilizers are intended to calm anxious patients there are differences in their actions — and in their effects. They have been divided into three categories — the rauwolfia group, the 'minor' tranquilizers, and the phenothiazines.⁵

Although the tranquilizing effect of rauwolfia has been known for centuries, its use as an antipsychotic agent in current practice has diminished.⁵

A 'minor' tranquilizer is often prescribed to achieve more than one effect. Thus, besides being tranquilizers some of these compounds may be muscle relaxants, antihistaminics with some calming action, anticholinergic sedatives, or antispasmodics.⁵

The phenothiazines are considered 'major' tranquilizers because they alter psychotic behavior.¹ This classification may have done them more harm than good because it implies that the phenothiazines should be reserved for the more

severely disturbed. This is not necessarily true.

The phenothiazines — and the problem of sedation

One of the problems of prescribing phenothiazines for ambulatory patients has been the fear that excessive sedation will impair the patient's ability to function. This, however, is less of a problem with some of the phenothiazines.

"Clinically they may be differentiated primarily in terms of their potency and the extent of their sedative effect, which appear to be inversely proportional. That is, the least potent, the one which is used in highest dosage, chlorpromazine, is the most sedative, while the reverse holds true for fluphenazine."⁶

In a recent report on various studies conducted over several years evaluating 360 patients treated for anxiety and stress with seven phenothiazines, this inverse relationship of potency to sedation was confirmed.⁷ Also under consideration was the degree to which the particular phenothiazines neutralized anxiety (the angolytic index). Interestingly enough there was, again, an inverse relationship. The most sedative of the phenothiazines appeared to be the least active in neutralizing anxiety. Flu-

phenazine, one of the least sedative, on the other hand, was found to be most effective in relieving anxiety.⁷

RELATIVE SEDATIVE AND ANGOLYTIC INDICES OF PRINCIPAL PHENOTHIAZINES*

DRUG	SEDATIVE INDEX	ANGOLYTIC INDEX	BASED ON STANDARD DOSE OF
Chlorpromazine	100	15	25 mgs.
Trifluorpromazine	100	15	25 mgs.
Thioridazine	90	17	25 mgs.
Perphenazine	15	25	4 mgs.
Carphenazine	25	25	25 mgs.
Trifluoperazine	3.3	95	2.0 mgs.
Fluphenazine	3.5	100	2.5 mgs.

*adapted from Sainz⁷

Prolixin is therapeutically effective without excessive sedation

When used as a 'tranquilizer' in general medical practice, in many patients Prolixin (Squibb Fluphenazine Hydrochloride) suppresses anxiety, but not normal activity. These two features are of particular importance to patients who must be able to live and work without their normal daily activities being restricted.

Because of its longer duration of action, Prolixin, in doses of as little as one to three milligrams in adults, generally taken once a day, is effective in maintaining many patients free of their symptoms of anxiety and tension.

Contraindications: Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use with caution in patients with a history of convulsive disorders. Severe reactions may occur in patients with idiosyncrasy to other centrally-acting drugs, and severe hypotension may occur in patients with special medical disorders, e.g. mitral insufficiency and pheochromocytoma.

Precautions: Effects of atropine, anesthetics and C.N.S. depressants may be potentiated. Hypotension may occur in patients undergoing surgery. Do not use epinephrine for treatment of the hypotensive reactions which may appear in patients on phenothiazine therapy.

Side Effects: Extrapyramidal reactions, allergic skin reactions, the possibility of anaphylaxis, drowsiness, visual blurring, dizziness, insomnia, nausea, anorexia, salivation, edema, perspiration, dry

mouth, abnormal lactation, polyuria, hypotension, and jaundice and biliary stasis may occur. Routine blood counts are recommended to determine possible blood dyscrasias; if symptoms of upper respiratory infection occur, discontinue drug and institute appropriate therapy.

Available: 1 mg. tablets. Bottles of 50 and 500.

For full prescribing information, see package insert.

References: 1. Simpson, G.M.: Postgrad. Med. 39:557, 1966. 2. Freyhan, F.A.: Am. J. Psychiat. 115:577, 1959. 3. Dorland's Illustrated Medical Dictionary, ed. 24, Philadelphia, W. B. Saunders Co., 1965, p. 1603. 4. Physicians' Desk Reference, 1966, Oradell, N.J., p. 310. 5. Cohen, S.: Northwest Med.: 65:197, 1966. 6. Detre, T., and Jarecki, H.: Connecticut Med. 25:553, 1961. 7. Sainz, A.: Psychosomatics 5:167, 1964.

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LOMOTIL[®]

tablets/liquid

Each tablet and each 5 cc. of liquid contains:
 diphenoxylate hydrochloride 2.5 mg.
 (Warning: May be habit forming)
 atropine sulfate 0.025 mg.

tackles the problem of diarrhea directly

Effectiveness—Physiologic evidence indicates that Lomotil acts directly on the smooth muscle of the bowel to lower motility and control diarrhea. This action is unsurpassed in promptness and efficiency.

Convenience—Lomotil is available as small, easily carried, virtually tasteless tablets and as a pleasant, fruit-flavored liquid.


Versatility—The therapeutic efficiency, safety and convenience of Lomotil may be used to advantage alone or adjunctively in diarrhea associated with:


- Functional hypermotility • Acute infections • Malabsorption syndrome • Drug therapy • Gastroenteritis and colitis • Irritable bowel
- Regional enteritis • Ileostomy • Ulcerative colitis • Food poisoning


*For correct therapeutic effect
 Rx correct therapeutic dosage*


Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are:


Children: Total Daily Dosage


3-6 mo. . . ½ tsp. t.i.d. (3 mg.) 


6-12 mo. . ½ tsp. q.i.d. (4 mg.) 

1-2 yr. . . ½ tsp. 5 times daily (5 mg.) 

2-5 yr. . . 1 tsp. t.i.d. (6 mg.) 

5-8 yr. . . 1 tsp. q.i.d. (8 mg.) 

8-12 yr. . 1 tsp. 5 times daily (10 mg.) 

Adults: 2 tsp. 5 times daily (20 mg.) 
 (or 2 tablets q.i.d.) 

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

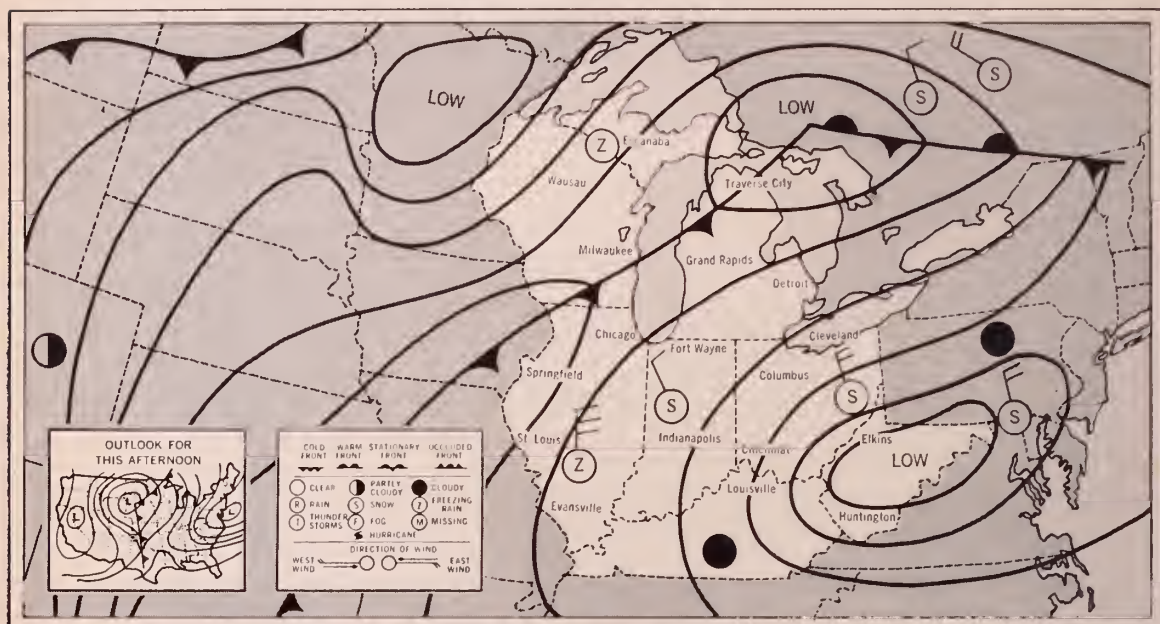
Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is a Federally exempt narcotic preparation of very low addictive potential. Lomotil should be kept out of reach of children since accidental overdosage may cause severe respiratory depression. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

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Tussagesic breaks up coughs, quickly clears stuffed and runny noses and relieves aches and pains. Provide coverage of the tough cold for up to 24 hours with just a single timed-release tablet dosed morning, midafternoon and at bedtime.

each

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timed-release tablet contains:

Triaminic [®]	50 mg.
(phenylpropanolamine hydrochloride 25 mg., pheniramine maleate 12.5 mg., pyrilamine maleate 12.5 mg.)	
Dextromethorphan hydrobromide	30 mg.
Terpin hydrate	180 mg.
Acetaminophen	325 mg.

Dosage: Adults—1 tablet, swallowed whole to preserve timed-release feature, in morning, midafternoon and at bedtime. **Side effects:** Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. **Precautions:** The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

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There is a growing senescent body of people who—either from lack of motivation, or as a result of surgery, trauma, or extended illness—are on their way to malignant inactivity...



The Mediatrix Age:

Unfortunately, there is no cure. But there are, largely through your own interest and direction, ways to help them back to a more active and useful life. There are medicines, too, designed to help. One such has proved useful in clinical practice:

"A steroid-nutritional compound (Mediatrix) was used in 100 patients to relieve some of the symptoms caused by degenerative changes of aging . . . This therapy resulted in improvement of 75 per cent of the patients . . ."

McNeill, A. J.: Clin. Med. 8:518 (Mar.) 1961.

"Mediatrix (steroid-nutritional compound) capsules, one a day, seem to give definite help to debilitated patients."

Arnold, E. T., Jr.: Geriatrics 12:612 (Oct.) 1957.

"Nutritional and hormone bolstering of function in the aged may have a useful place in geriatrics."

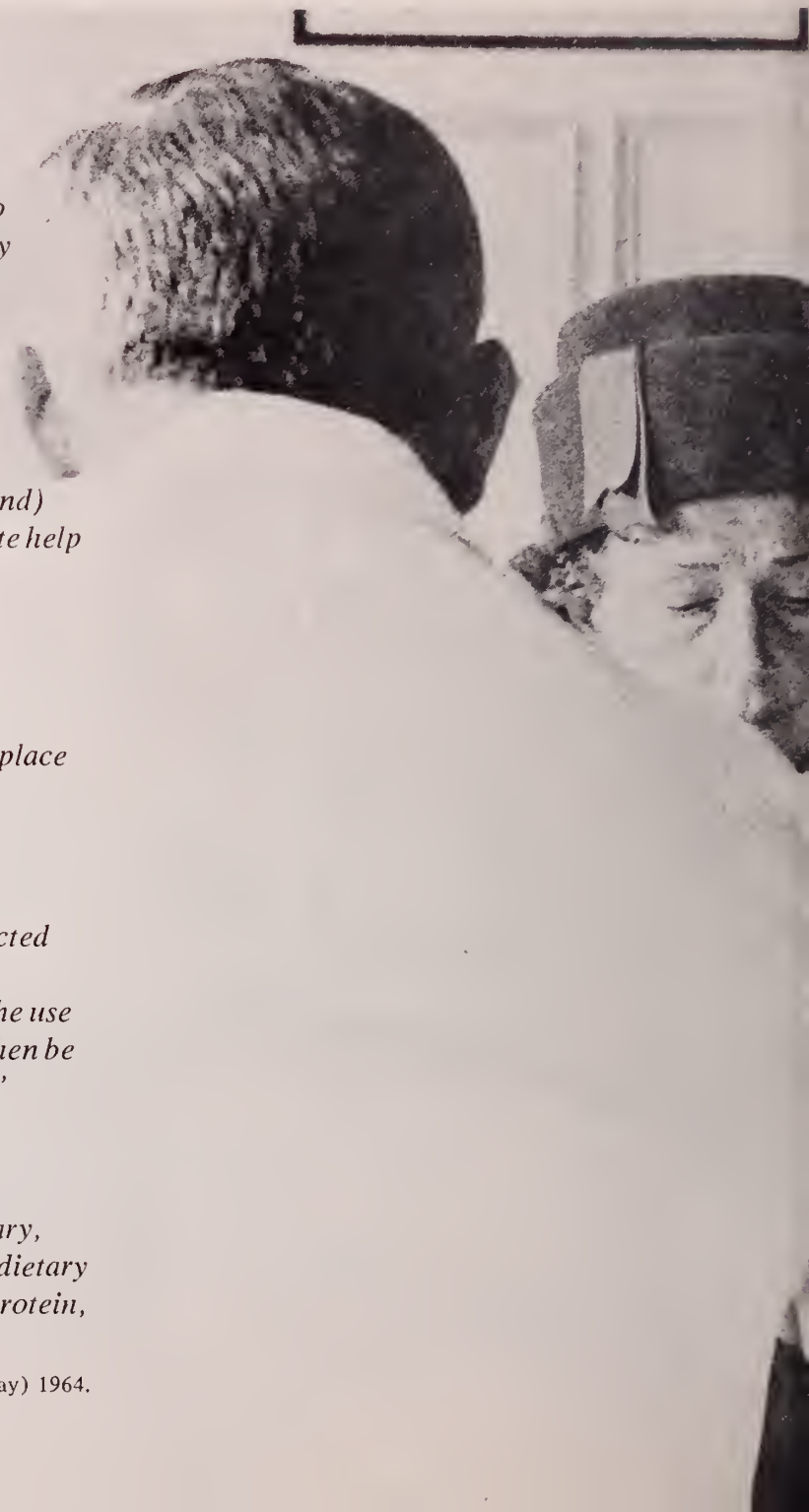
Morgan, A. F.: Gerontologist 2:77 (June) 1962.

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Morgan, A. F.: Gerontologist 2:77 (June) 1962.

"Intensive nutritional therapy is necessary, especially in elderly people, to correct dietary deficiencies created by large losses of protein, vitamins and other nutrients."

Riccitelli, M. L.: J. Am. Geriatrics Soc. 12:489 (May) 1964.



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Nutritional reinforcement for those who can't
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estrogen and androgen to counteract declining
gonadal hormone secretion and its sequelae of
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The estrogen component in MEDIATRIC is PREMARIN® (conjugated estrogens—equine), the natural estrogen most widely prescribed for its superior physiologic and metabolic benefits.

MEDIATRIC also provides *nutritional reinforcement—blood-building factors and vitamin supplementation*. It contributes a gentle “mood” uplift through methamphetamine HCl.

Three different dosage forms—Liquid, Tablets, and Capsules—offer convenience and variety.

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Each 15 cc. (3 teaspoonfuls) contains:

*Conjugated estrogens—equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
Thiamine HCl	5.0 mg.
Cyanocobalamin	1.5 mcg.
Methamphetamine HCl	1.0 mg.

Contains 15% alcohol

MEDIATRIC Tablets and Capsules

Each MEDIATRIC Tablet or Capsule contains:

*Conjugated estrogens—equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
Ascorbic acid	100.0 mg.
Cyanocobalamin	2.5 mcg.
Intrinsic factor concentrate	8.0 mg.
Thiamine mononitrate	10.0 mg.
Riboflavin	5.0 mg.
Niacinamide	50.0 mg.
Pyridoxine HCl	3.0 mg.
Calc. pantothenate	20.0 mg.
Ferrous sulfate exsic.	30.0 mg.
Methamphetamine HCl	1.0 mg.

*Orally active, water-soluble conjugated estrogens derived from pregnant mares' urine and standardized in terms of the weight of active, water-soluble estrogen content.

MEDIATRIC helps keep the older patient alert and active; helps relieve general malaise, easy fatigability, vague pains in the bones and joints, loss of appetite, and lack of interest usually associated with declining gonadal hormone secretion.

CONTRAINDICATION: Carcinoma of the prostate, due to methyltestosterone component.

WARNING: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.

SIDE EFFECTS: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.

SUGGESTED DOSAGES: *Male and female:* 3 teaspoonfuls of Liquid, 1 Tablet, or 1 Capsule, daily or as required.

In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

SUPPLIED: No. 910 — MEDIATRIC Liquid, in bottles of 16 fluidounces and 1 gallon. No. 752 — MEDIATRIC Tablets, in bottles of 100 and 1,000. No. 252 — MEDIATRIC Capsules, in bottles of 30, 100, and 1,000.

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Whenever tetracycline is indicated in these candidates for Candida:

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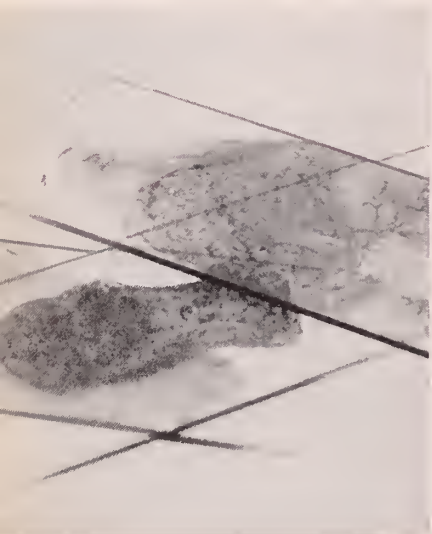
2. nonpregnant women with a history of recent or recurrent monilial vaginitis



3. elderly or debilitated patients



4. patients with a past history of moniliasis



5. patients on long-term tetracycline or corticosteroid therapy



BRISTOL THERAPEUTIC SUMMARY: For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discoloration occurs. With renal impairment, systemic accumulation of tetracycline may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfection may occur. Infants may develop increased intracranial pressure with bulging fontanelles. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, leukopenia, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue therapy for 10 days in beta-hemolytic streptococcal infections. Administer one hour before or 2 hours after meals. *Supply:* Capsules, bottles of 16. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin.

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Each capsule contains tetracycline phosphate complex equivalent to tetracycline hydrochloride 250 mg. and nystatin 250,000 units

Tetrex-F is priced lower
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CONSIDER **DEXAMYL**[®] FIRST
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Often within the hour, 'Dexamyl' works
to help dispel such symptoms as apathy,
pessimism, loss of interest and initia-
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Formulas: Each 'Dexamyl' Spansule[®] capsule (brand of sustained release capsule) No. 1 contains 10 mg. of Dexedrine[®] (brand of dextroamphetamine sulfate) and 1 gr. of amobarbital, derivative of barbituric acid [Warning, may be habit forming]. Each 'Dexamyl' Spansule capsule No. 2 contains 15 mg. of Dexedrine (brand of dextroamphetamine sulfate) and 1½ gr. of amobarbital [Warning, may be habit forming].

The following is a brief precautionary statement. Before prescribing, the physician should be familiar with the complete prescribing information in SK&F literature or PDR.

Precautions: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Do not use in patients taking MAO inhibitors. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence; in these instances, withdraw the medication. Use cautiously in pregnant patients, especially in the first trimester. *Side effects:* Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.



SMITH KLINE & FRENCH LABORATORIES



Others Are Saying

A Quick Look at Health Costs

President Johnson has ordered federal officials to take "a hard and very quick look" at rising medical care costs. This order, coming two months after the start of the Medicare program, will increase fears of the medical profession that Medicare will mean greater federal government control over medical practices.

However, a fact-finding study is not objectionable and can be in the public interest. What measures the Administration takes after its study will determine whether the doctors' fears are realistic. Perhaps the Administration will do no more than point up the extent to which costs are rising and urge the medical profession to use restraint. Perhaps it will suggest guidelines for medical charges.

The problem of rising medical costs is complicated. The Labor Department's cost of living statistics show that the greatest cost increase in recent years has not been in doctor's fees but in hospital charges.

Physicians' fees rose to 121.2 per cent of the 1957-59 average in June, 1965, and to 125.5 per cent in June, 1966. Hospital charges rose to 152.2 per cent of the 1957-59 average in June, 1965, and to 164.2 per cent a year later.

Drug prices, another major item in medical care costs, rose only slightly during this period.

Hospital costs seem certain to continue to rise. A major reason for this is higher wages for nurses

and other hospital personnel, which have been low in relation to wages in other occupations. The shortage of nurses and other hospital personnel probably can't be relieved except by paying competitive wages.

If Medicare results in more older people going to hospitals and staying there longer, it will aggravate the nurse shortage problem. Other hospital costs, for food, supplies and additional facilities, are rising also.

Some explanations for rising physicians' charges are the same as for higher prices in other fields—general inflation, higher costs for nurses, office help, rent, etc.

Questions which arise about higher physicians' fees stem largely from the effect of Medicare. Doctors will now get fees from many of those elderly patients who were formerly treated as charity patients for no fees. Some doctors also have charged low income patients less than they charged high income patients. They may now abandon the practice of having wealthy patients subsidize the cost of treating elderly charity and low income patients.

The effect of these changes stemming from Medicare needs study by both the medical profession and the government. We doubt that a "very quick look" will provide the necessary information.

Reprinted from the Gainesville Daily Sun, September 1, 1966.

'Free' Services Costly

Britain is in an understandable tizzy because so many of its young medical men are "defecting" to the United States.

Says health minister Kenneth Robinson: "Britain simply cannot afford to train doctors for the purpose of swelling the membership of the American Medical Association."

The doctors' position is understandable, too. Under the British state-run health program, they are overworked and underpaid. Some put in a 110-hour week. Their starting salary is about \$2,000 a year.

It's different in this country right now, but who can predict the future? We have Medicare, under which the taxpayers are paying some of the medical bills of a selected group of people. As time goes on, the law may be revised to include the care of other age groups.

Eventually, it may be extended to become a national health service like the one which Britain adopted 18 years ago—and is now beginning to wonder if it was a wise move after all.

The British plan to provide free medical serv-

ice to all is threatened with a disastrous breakdown. In addition to the mounting doctor shortage, British hospitals present another major problem.

"Unless vast new sums of money are made available—from some source or another," says a spokesman for the British Medical Association, "the present concept of hospital service must be abandoned. . . . Half the nation's hospitals are more than 80 years old, and only two new general hospitals have been built since 1939."

The BMA report concludes: "If the public wishes to have an unrestricted health service, it must be prepared to pay for it."

That goes for this country, too. It should be remembered that there is no such thing as a "free" service. Nothing in this world is free, and that "law" has not been repealed by Medicare.

Before any steps are taken to expand or extend it, a thorough study should be made of Britain's experience.

Reprinted from the West Palm Beach Post, September 20, 1966.

Format Change Honors Advertisers

In appreciation to all the fine advertisers who, through the years, have shown faith in the state medical journal as an advertising medium, the Journal of the Florida Medical Association is pleased to announce a new approach to its handling of the Index to Advertisers.

Beginning this month on page 1242, the Journal's Index to Advertisers has been expanded to a full page. Each product advertised is given a separate listing under the name of the participating advertiser.

The Journal also wishes, through this change in format, to encourage the physicians of Florida to patronize the Journal advertisers. Without their continued support the Journal would not be possible.

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Colon and Rectal Surgery
Rees B. Rees, M.D., San Francisco, Calif.
Dermatology
Jose M. de la Vega, M.D., Mexico, D. F.
Gastroenterology
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Gordon W. Douglas, M.D., New York, N. Y.
Gynecology
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For information concerning the Assembly meeting, write Secretary, The New Orleans Graduate Medical Assembly, Room 1528, 1430 Tulane Avenue, New Orleans, Louisiana 70112.



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*Schiller, I. W., and Lowell, F. C.: New England J. Med. 261:478, 1959.

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requiring mental alertness while taking this agent. Bacterial or mycotic superinfection may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for three months. **Adverse Reactions:** Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis and allergic reactions may occur. **Usual Adult Dose:** Two capsules q.i.d. Continue therapy for at least 10 days in beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. **Supplied:** Bottles of 24 and 100.

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MOLECULAR REMODELING—

laboratory exercise or clinical necessity?

More than twenty-five years have passed since the discovery of the diuretic activity of sulfanilamide started pharmacologists on a succession of molecular remodelings to find the ideal diuretic.

Diuresis—a sought-after clinical effect from an unwanted side effect

It started in 1937 when a clinician reported that the administration of a sulfonamide was sometimes accompanied by an unexplainable side effect—metabolic acidosis.¹ Three years later the side effect was explained. The sulfonamide radical of sulfanilamide inhibited carbonic anhydrase,² the enzyme responsible for converting carbon dioxide and water to hydrogen ions and bicarbonate ions.

Later, other investigators showed by dog experiments that metabolic acidosis probably resulted when the inhibition of carbonic anhydrase upset the exchange of hydrogen and sodium ions, causing increased excretion of sodium as the bicarbonate.³

It was twelve long years after the first report of the unexplainable side effect (metabolic acidosis) that it was finally shown that large doses of sulfanilamide administered to edematous patients were indeed capable of promoting diuresis.⁴ However, the possibility of toxic effects from its prolonged use and its relatively weak diuretic action made it impractical for clinical use as a diuretic.⁵

Because the inhibition of carbonic anhydrase seemed to be the key to effective diuresis, investigators began to look for more potent enzyme inhibitors—in the hopes that they would be more effective diuretics.

The most important of these early compounds, acetazolamide, enjoyed several years of fairly wide clinical use.

Its carbonic anhydrase inhibitory activity was several hundred times greater than that of sulfanilamide.⁶ The increase in inhibitory activity, however, increased not only the excretion of sodium and bicarbonate ions, but also the excretion of potassium.⁷ And, like its predecessor, acetazolamide precipitated mild acidosis. Its prolonged use could result in hypokalemic acidosis.⁷

The 'thiazides'—an answer to the metabolic acidosis caused by carbonic anhydrase inhibition

Despite the fact that the sulfonamide

group appeared to be responsible for carbonic anhydrase inhibition which in turn appeared to be responsible for diuresis, investigators began to synthesize compounds with structural alterations to the sulfonamide group.

The first major breakthrough came with the synthesis of chlorothiazide. Altering the sulfonamide group did indeed alter the ability of chlorothiazide to inhibit carbonic anhydrase—it was only 1/10th as potent as acetazolamide in inhibiting the enzyme.⁸ Despite the drop in inhibitory potency, however, chlorothiazide proved to be an effective diuretic—an observation that led to the conclusion that its diuretic action was due to some mechanism other than its action on carbonic anhydrase.^{9,10}

For effective diuresis, chlorothiazide was administered in daily dosages ranging from 250 to 2000 mg.¹¹ It increased the excretion of sodium and chloride; and, to a lesser extent, potassium and bicarbonate.¹¹ The excretion of potassium appeared to be maximal at higher dose levels at which, theoretically, the carbonic anhydrase inhibitory effect is more active.¹¹ Its prolonged use, therefore, could sometimes result in metabolic hypokalemic, hypochloremic alkalosis.⁷

Naturetin—effective diuresis with more favorable electrolyte balance

Other thiazides followed—with improvements being aimed at two particular areas: 1. attempts to increase diuretic action in relation to the milligram potency of the drug, and 2. attempts at a more favorable sodium/potassium ratio in the urine, i.e., to decrease the excretion of potassium while maintaining the excretion of sodium.¹²

One of these, Naturetin, Squibb Bendroflumethiazide, has made advances on both these points. "By adding a 3-benzyl radical to hydroflumethiazide a rather dramatic reduction in dose range is accomplished. With this drug, effective sodium excretion is obtained with

doses between 2.5 and 10 mg., which is a 200 to 1 ratio as compared to chlorothiazide..."¹³

Moreover, due probably to its virtual lack of carbonic anhydrase inhibition, Naturetin (bendroflumethiazide) has been shown to cause less potassium and bicarbonate loss and less alteration in urinary pH than either chlorothiazide or hydrochlorothiazide.

Naturetin is outstandingly effective not only in establishing, but also in maintaining, excretion of retained fluid in edematous patients. And its duration of action is sufficiently prolonged to allow a single daily administration in most patients. Naturetin is also an effective antihypertensive agent.

Contraindications: Severe renal impairment; previous hypersensitivity.

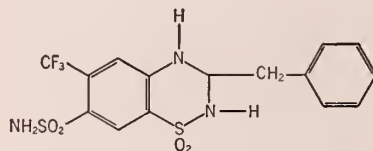
Warning: Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting, or G.I. bleeding occur.

Precautions: The dosage of ganglionic blocking agents, veratrum, or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Electrolyte disturbances are possible in cirrhotic or digitalized patients.

Side Effects: Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycosuria and glycosuria in diabetic patients and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, and rashes may occur.

Supplied: Naturetin (Squibb Bendroflumethiazide) 5 mg. and 2.5 mg. tablets. Also available Naturetin \bar{c} K [Squibb Bendroflumethiazide (5 or 2.5 mg.) with Potassium Chloride (500 mg.)]. For full information, see Product Brief.

References: 1. Southworth, H.: Proc. Soc. Exper. Biol. & Med. 36:58, 1937. 2. Mann, T. and Keilin, D.: Nature 146:164, 1940. 3. Pitts, R. F., and Alexander, R. S.: Am. J. Physiol. 144:239, 1945. 4. Schwartz, W. B.: New England J. Med. 240:173, 1949. 5. Friedberg, C. K., in Moyer, J. H., and Fuchs, M.: Edema Mechanisms and Management, Philadelphia, W. B. Saunders Co., 1960, p. 259. 6. Cumming, J. R.; Tabachnick, E., and Seelig, M., in Moyer, J. H., and Fuchs, M.: op. cit., p. 254. 7. Werko, L., in Moyer, J. H., and Fuchs, M.: op. cit., p. 188. 8. Beyer, K. H., Jr., in Moyer, J. H., and Fuchs, M.: op. cit., p. 274. 9. Maren, T. H., and Wiley, C. E.: J. Pharmacol. & Exper. Therap. 143:230, 1964. 10. Earley, L. E., and Orloff, J.: Ann. Rev. Med. 15:149, 1964. 11. Fuchs, M., and Mallin, S. R., in Moyer, J. H., and Fuchs, M.: op. cit., p. 276. 12. Ford, R. V., in Moyer, J. H., and Fuchs, M.: op. cit., p. 290. 13. cited in Fuchs, M., and Mallin, S. R. (ref. 11): op. cit., p. 283.



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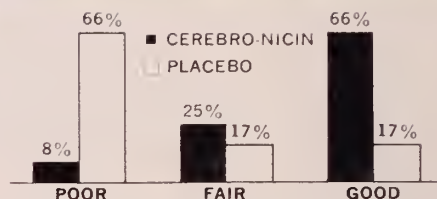
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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg, Jnt. of the Amer. Ger. Soc., June, 1964.

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The Medical Detective



Death During Toxic Psychosis

The attendants in an emergency room of a large general hospital were startled early one morning by a crashing sound just outside. They rushed out to find the body of a patient who had either jumped or fallen from an upper floor window.

Upon being brought to the emergency room, the deceased was identified as a 31 year old woman admitted earlier in the evening with a tentative diagnosis of pneumonia. The history indicated she was known to drink heavily occasionally and that for the past week she had been bedridden with severe fever and coughing. Her mother stated the patient had eaten little and taken only some clear fluids. No previous history of suicide attempts or psychiatric treatment existed.

The ward nurse stated an attendant had taken the patient's temperature about 30 minutes before death and noticed nothing unusual at that time except a temperature of 104F. Examination

of the room revealed it to be in order and no suicide note was found. Another patient occupying the room had not been aware of any unusual noises. The screen had been removed after the window was opened and the patient apparently crawled out and either jumped or fell.

Autopsy revealed the death to be due to crushing injuries to the head and neck. The most significant finding was a classic hepatization of the middle and lower lobe of the right lung. Lobar pneumonia, through complication of a toxic psychosis, was the most likely explanation for this patient's behavior.

This complication is seen infrequently today, but certainly might be expected in any case in which high febrile and toxic states exist. Lobar pneumonia is encountered clinically today most frequently in alcoholics and at autopsy in the medicolegal investigation of unexpected deaths of derelicts.

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Brief Summary

Indications: Use Erythrocin-Sulfas in infections more susceptible to the combination than to either agent alone. These are usually found in urinary, lower respiratory tract, and chronic ear infections.

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or new born infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions: Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

If a reaction or overgrowth of nonsusceptible organisms occurs, withdraw the drug.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. each of sulfadiazine, sulfamerazine and sulfamethazine. 603303



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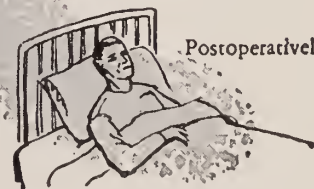
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Ten years ago, a California physician whose daughter almost died as a result of a reaction to a skin test for tetanus antitoxin founded the Medic Alert Foundation International. Today more than 160,000 people wear the nonprofit Foundation's increasingly familiar stainless steel emblem on the wrist or around the neck, each calling immediate attention to one or more of 200 hidden medical problems.

When necessary, by placing a collect telephone call to the Foundation's Turlock, California headquarters, physicians and other authorized personnel may obtain additional medical information that may save the life of a conscious or unconscious person wearing a Medic Alert emblem. The telephone number 209-634-4917 appears on all emblems.

Each emblem carries the words "Medic Alert" and the staff of Aesculapius emblazoned in red enamel. The reverse side of the emblem contains one or more key words, the Foundation's telephone number and the wearer's identifying number corresponding to an information card in the Medic Alert files. Thus in an emergency, physicians or others, at any hour of the day or night, can call the Foundation's central answering file

and obtain further medical facts plus the wearer's name and address, his next of kin and the name of his family or personal physician.

Some emblem wearers are laryngectomees, others have a collapsed lung or Meniere's disease or some other problem. The youngest emblem wearer is one year old, the oldest is 92.

The American Medical Association estimates that 40 million Americans—one in five—should be wearing a medical signaling device.

The one-time cost of a Medic Alert emblem and a round-the-clock information service is \$5.00 (sterling silver emblems are \$7.50.) The Foundation, however, provides membership without cost for persons whose physicians state they are unable to pay.

The Foundation has a dual purpose: first, to educate people who need to obtain and *wear* an emblem, and second, to teach physicians and qualified first aid personnel to *look* for the emblem. Thirty national and overseas airlines now instruct their hostesses to look for Medic Alert emblems, and many industries provide information about Medic Alert in their industrial health programs.



NEWS

Hospital Emergency Department Improvement Suggested By New AMA Handbook

Ways must be found to ease the rising pressures on hospital emergency services if emergency medical care is to be improved in the United States.

A report in the October 24 Journal of the American Medical Association states that Emergency Departments have been "the most neglected and often the weakest in the hospital."

The report is the first chapter of a new AMA handbook which will offer suggestions on improvements. The handbook, "Emergency Department—A Handbook for the Medical Staff," will be available later this fall. It is part of the AMA's recently announced plan to upgrade emergency medical care throughout the nation.

The big change in emergency service is that in addition to an increase in genuine medical emergencies, there have been tremendous increases in requests for "drop-in" medical care. The emergency department is no longer what it was several years ago: a room reserved only for accident cases which required prompt first aid.

A recent study found that 42 per cent of the cases treated in some hospital emergency departments were not emergencies.

One view, said the report, is that "anyone who comes to the emergency department wanting to be attended by a physician, regardless of his condition, should not be turned away. The axiom—what may not be emergent to the physician may certainly be to the patient—applies in this case. In these times of rapid changes in medical practice and of medical awareness of the public, the community hospital must accept the public's definition of the emergency department—a place to get medical aid in a hurry."

"The number of emergency department visits has increased faster than either hospital inpatient admissions or outpatient visits," the report said, "and indications are that these trends will continue."

Statistics of the American Hospital Association show that emergency department visits increased by 16 million, or 175%, between 1954 and 1964.

Spinal Cord Injury Symposium To Be Held

Specialists in the treatment of spinal cord injuries participated in an unusual symposium at the annual convention of the National Society for Crippled Children and Adults, Friday, November 11, at the Penn-Sheraton Hotel, Pittsburgh.

Headed by Dr. James B. Campbell, research professor, neurological surgery, New York University Medical Center, the group discussed causes, as well as the highly specialized surgical techniques, nursing care and therapy involved in paraplegia and other conditions.

Dr. Campbell's subject was "The Paraplegic Child: Causes and Therapeutic Approach to the Problem."

Summarizing the symposium was Dr. Mary D. Ames, coordinator of rehabilitation services, Children's Hospital, Philadelphia, and Elizabethtown Crippled Children's Hospital.

Dr. James B. Johnson Jr., Newark, Ohio, member of the National Society's board of directors, was chairman of the symposium.

Football Knee Injury Prevention Methods

Suggested By SHSAA and AMA Committee

Prevention of knee injuries in football should rate priority attention, even though protecting the knee is difficult.

A joint statement by the National Federation of State High School Athletic Associations and the American Medical Association's Committee on the Medical Aspects of Sports offers suggestions for greater player protection.

The best protection, the statement said, may be the player's own efforts to build strength in leg muscles supporting the knee. These are the knee's only supporting structures in which strength can be improved.

It is a paradox that the knee—considered one of the strongest joints in the body—is the most commonly injured major joint in contact sports, the statement noted. This is partly due to the knee's unusual structure. It is more than a mere hinge; the leg must rotate as the joint hinges. This versatile joint movement makes possible the crowd-thrilling action of a dodging, weaving football "scat back." On the other hand, the complexity of the knee's structure also makes the player vulnerable to disabling injury.

Bad practices cause many knee injuries, the statement said, and such practices can only be eliminated by better

coaching and strict control of the game. These practices include clipping, blind-side blocking, piling-on after tackles, and unnecessary contact after an official's whistle has sounded.

Knee pads help avoid bruise-type injuries, but protective equipment otherwise offers primarily only psychological benefits. The player can help prevent injury by following his coach's advice to shorten and quicken his stride when in the zone of action. This lessens the time a foot is on the ground—the only time a knee injury can occur.

Some football shoes now have cleatless heels, an effort to prevent knee injury by giving the foot more freedom of movement. Results to date are encouraging, but continued study is recommended to learn more specifically the relative advantages of cleatless heels.

If it were possible, the best way to prevent knee injury would be to select only athletes who were bowlegged and pigeon-toed, the statement noted. These leg alignments permit the least possible stress on the knee. Beyond such an impractical solution, the best protection remains adherence to good practices, strict rule enforcement, and building-up of strength in the thigh, hamstring, and calf muscles.

AMA Proposes New 'Family Physician' Medical Specialty

The American Medical Association's Council on Medical Education sought authorization from the House of Delegates in November to develop and initiate plans for creation of a new specialist—the family physician.

The Council's action was made on the basis of recommendations in a major report by its Ad Hoc Committee on Education for Family Practice, The AMA News reported in its October 24 issue.

The committee was charged in September 1964 to review AMA policy regarding the future of family practice and to recommend the educational approach by which the goals of such policy might be achieved.

In its report, the committee said preparation of a sufficient number of family physicians to meet the public need is "a major national problem" requiring a "bold approach" with the "full cooperation of medical educators and the practicing profession.

"These physicians should be specialists prepared through new kinds of educational programs to meet the medical care needs of the future. As specialists, they should be entitled to appropriate specialty board certification."

Dedicated To Dr. Charles Stein

Editor's Note: The Journal is pleased to publish the following poem as one of a series dedicated to her various physicians by Mrs. Leona Levin, a retired schoolteacher of Miami Beach who has been crippled by arthritis. Mrs. Levin writes under the pen name of Lena Lin Louis. The poems are presented as examples of all-too-rare expressions of gratitude to physicians. The doctors whose names appear have granted permission for their use.

T. M.

Dear Charles, I want to thank you:

For the kind personal interest you took in us,
Your many thoughtful deeds without fanfare or
fuss.

We greatly valued your wise advice
To make Harriet comfortable, you tried every
device.

Gas, ether and all that other stuff
To put Harriet to sleep wouldn't have been
enough.

Even the pills, the injections of sleeping juice,
Would have been of negligible use.
I'm sure it was because of your serene soothing
voice,
Harriet slipped into the arms of Morpheus
without a second choice.

Charles, we have great confidence in your ability
To keep a patient in a state he should be.
Your diligent and careful observations
Bring through the most serious operations.

When a doctor's practice covers every field
As was the way in days of yore
I would feel very safe and content to yield
To your general knowledge of the medical
score.

A man of your gifted ability,
Must have a wife of divine serenity,
Knowing Lois and the children, I know your home
is one of ecstasy.

LENA LIN LOUIS
Corny but sincere



AMA Proposes Rural Emergency Care Plan

The American Medical Association's Council on Rural Health recently offered a five point program for improving emergency medical care in rural areas. The program is the first step in a larger AMA project to insure nationwide excellence of emergency care.

As outlined by the council, the program particularly stresses wider first aid training for rural Americans and swifter handling of emergency victims.

Bond L. Bible, Ph.D., secretary of the council, pointed out that a study of traffic fatalities indicates that "people injured in rural counties were almost four times as likely to die of their injuries as those injured in urban counties, despite the occurrence of less severe accidents and more survivable injuries.

"The higher case fatality ration in rural areas seems to be related to the inability to provide adequate first aid procedures and to get the person to a hospital within a reasonable period of time," Dr. Bible said.

"In addition to motorists, emergency medical transportation and first aid arrangements are also highly important to farm families," he continued. "The National Safety Council reports that 740,000 disabling injuries occurred on farms during 1965 and that farming ranks third behind mining and construction jobs in accidental death rates."

The rural health council's program, approved by the AMA Board of Trustees, urges that:

1. Rural communities coordinate their efforts with adjacent towns or urban centers in analyzing existing patterns of response to medical emergencies.

2. Rural and urban communities institute a medical service area program for emergency medical transportation facilities and health personnel.

3. Rural and urban communities, where possible, adopt the model ambulance ordinance to give the public a greater voice in the quality of ambulance care. The model ordinance proposes standards for ambulance equipment, personnel and operation, liability insurance requirements, maintenance of records, duties of regulatory agencies and penalties to be imposed if the ordinance is disobeyed.

4. Rural and urban communities provide a program of advanced Red Cross first aid instruction for the nonmedical people most frequently called in rural emergencies—especially police, sheriffs, and ambulance crews.

5. Rural and urban communities develop a continuing campaign directed toward first aid instruction for rural families and particularly young people through the schools, youth organizations and other educational channels.

Assisting in organizing and implementing the program are the American Red Cross, Federal Extension Service, Department of Health, Education, and Welfare, National Education Association and the National Grange and American Farm Bureau Federation.

**brings
peace to the
hyperactive
colon**



CANTIL[®] (mepenzolate bromide)

helps restore normal motility and tone

"In 40 of 44 cases of irritable or spastic colon, Cantil [mepenzolate bromide] or Cantil with Phenobarbital reduced or abolished abdominal pain, diarrhea and distention and promoted restoration of normal bowel function... Cantil [mepenzolate bromide] proved to be singularly free of anticholinergic side-effects... Urinary retention, noted in two cases was eliminated in one by reducing dosage."¹

IN BRIEF: One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withdraw in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

Supplied: CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

¹ Riese, J. A.: Amer. J. Gastroent., 28:541 (Nov.) 1957

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Dactil® (piperidolate hydrochloride), 50 mg.;
Standardized cellulolytic* enzyme, 2 mg.;
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Standardized proteolytic enzyme, 10 mg.;
Pancreatin 3X** (source of lipolytic activity),
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*Need in human nutrition not established.

**As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.



In chronic or acute indigestion, fluttery, gassy stomachs obtain prompt, gratifying relief through the antispasmodic, surface anesthetic and enzymatic activity of Dactilase. Dactilase decreases hypermotility and pain and reduces the production of gas. Dactilase does not induce stasis, but helps restore normal tone. It has little or no effect on enzyme secretions, but *adds* enzymes, thus contributing to the digestive efficiency of the patient.

Side Effects and Contraindications:

Dactilase is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

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Each chewable tablet contains:
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aminoacetic acid (glycine) 750 mg.

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Side effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is a concomitant administration of a coronary vasodilator.

Supplied: Packages of 50 chewable tablets.

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DENOMINATOR? ... IRON



In fact, there's as much iron...250 mg.
...in a 5 cc. ampul of Imferon (iron dextran
injection) as in a pint of whole blood.
When iron deficient patients are intolerant
of oral iron...or orally administered iron
proves ineffective or impractical...or if
the patient cannot be relied upon to take oral
iron as prescribed, Imferon (iron dextran
injection) dependably increases hemoglobin
and rapidly replenishes iron reserves.

IMFERON® (iron dextran injection)

IN BRIEF: ACTION AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion as a source of iron; infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb/100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. Initial test doses are advisable. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylatoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

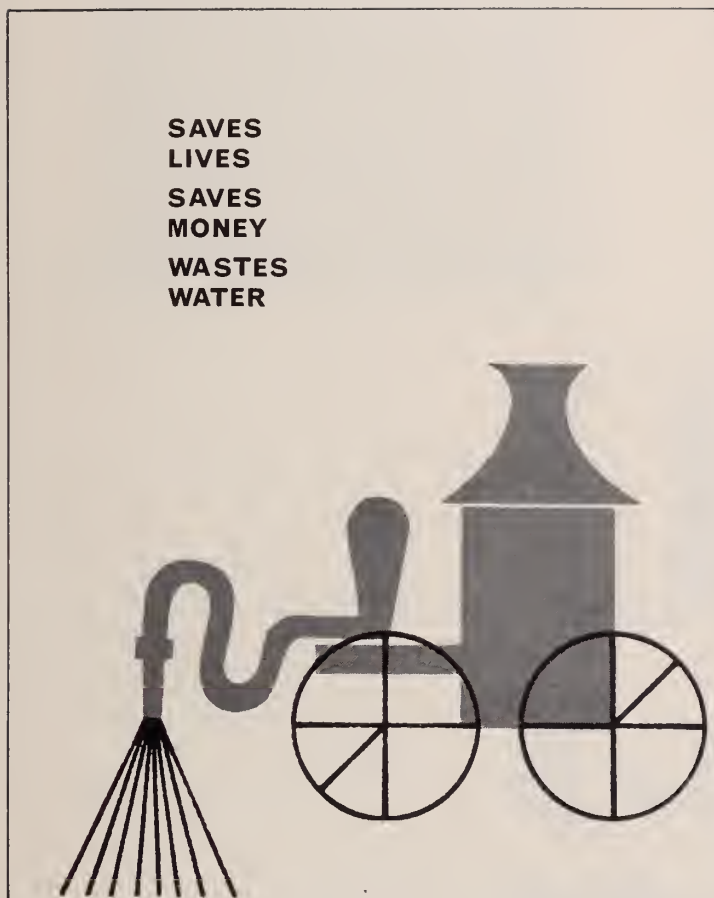
SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

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SAVES
MONEY
WASTES
WATER**



METAHYDRIN (trichlormethiazide) is prescribed by physicians because it not only approximates the diuretic efficacy of parenteral meralluride injection . . . but, *it is the least expensive of all "brand-name" thiazides.* Therefore, when you prescribe METAHYDRIN (trichlormethiazide) your patients receive the thiazide diuretic that removes a little more salt and water than earlier thiazides, with relatively less loss of potassium . . . and, it's therapy they can more easily afford . . . *only pennies a day.*

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oral diuretic

Dosage: One 2 or 4 mg. tablet once or twice daily.

Precautions: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

Side Effects: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have occasionally been noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by the administration of thiazides.

Contraindications: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

How Supplied: Bottles of 100 and 1000 tablets.

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AND
KEEP IT DOWN**

190
102

Metatensin lowers blood pressure and keeps it low—effectively and economically. It combines reserpine with trichlormethiazide which affords more potent saluresis with less loss of potassium than from earlier thiazides. Reserpine contributes antihypertensive effect by relieving anxiety and tension. Metatensin is well-tolerated over long periods; with its effectiveness and economy it assures antihypertensive therapy you and your patients can stay with.

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Each scored tablet contains:
METAHYDRIN® (trichlormethiazide)
2 mg. or 4 mg. and
Reserpine 0.1 mg.

Usual adult dose: One tablet twice daily. **Precautions and side effects:** Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery.

Contraindications: Complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.

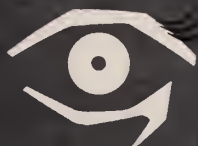
Supplied: Metatensin tablets, 2 mg., 4 mg.—bottles of 100 and 1000.

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"I can't sleep at night"



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Norpramin (desipramine hydrochloride) often reverses the signs and symptoms of depression including sleep disturbances, feeling of sadness, guilt, anxiety, worthlessness and bodily complaints without physical basis. In 2-5 days most patients become more hopeful, active and less weighed down by their problems.

Norpramin (desipramine hydrochloride) has only slight sedative qualities, nevertheless sleep disturbances and restlessness are relieved as depression is lifted. If anxiety or tension develop or persist a tranquilizer may be added or dosage reduced. Side effects are usually mild, occurring in about 1 of 4 patients.

Indications: In moderate to severe depression—neurotic or psychotic. **Dosage:** Optimal results are obtained at a dosage of two 25 mg. tablets t.i.d. (150 mg./day). **Contraindications and Precautions:** Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease and epilepsy. Should not be given within two weeks of an MAO inhibitor. Safety in human pregnancy has not been established. **Adverse Effects:** Usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste", sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs. **Supplied:** Norpramin (desipramine hydrochloride) tablets of 25 mg., in bottles of 50, 500 and 1000.

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QUIETS PARENTS
QUIETS **COLIC**

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each cc. contains 6 mg. phenobarbital (warning: may be habit forming); 4 mg. Piptal® (pipenzolate bromide), and 20% alcohol.

Pleasant-tasting Pediatric Piptal with Phenobarbital is miscible in milk, formulas and fruit juices, and may also be given by dropper directly on the infant's tongue. Dosage is 0.5 cc. 15 minutes before feeding; in severe cases, 1.0 cc. four times daily. High doses may occasionally cause constipation with tenesmus and, rarely, flushing without fever. It is contraindicated in bowel obstruction or sensitivity to phenobarbital or anticholinergics. Available in 30 cc. dropper bottles, droppers calibrated to deliver 0.5 cc.

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December

- 1- 3 "The Lower Extremity Amputee—Surgery and Prosthetic Management," University of Miami, Americana Hotel, Miami Beach.
- 1- 4 Fourth Annual Cardiology Seminar, Rogers Heart Foundation, Tides Bath Club, St. Petersburg.

January

- 2- 6 Neuro-Ophthalmology Symposium, Bascom Palmer Eye Institute, Americana Hotel, Bal Harbour.
- 5- 7 Postgraduate Seminar in Surgery, University of Miami Department of Surgery and FMA, Fontainebleau Hotel, Miami Beach.
- 13-14 Birth Defects Seminar, National Foundation and Jacksonville Hospitals Educational Program, St. Vincents Hospital, Jacksonville.
- 13-15 "Current Concepts in Treatment and Diagnosis of Central Nervous System Neoplasms," University of Miami School of Medicine, Eden Roc Hotel, Miami Beach.
- 15-20 "Acid Base Disorders in Internal Medicine, Surgery and Pediatrics," University of Miami School of Medicine, Fontainebleau Hotel, Miami Beach.

February

- 8-17 Psychiatry in Medical Practice, Advanced Course, University of Miami School of Medicine, Jackson Memorial Hospital, Coral Gables.
- 8-17 Psychiatry in Medical Practice, Basic Course, University of Miami School of Medicine, Jackson Memorial Hospital, Coral Gables.

March

- 17 Psychiatry Seminar, University of Florida College of Medicine, Gainesville.
- 17 "Psychosomatic Aspects of Gastrointestinal Disease" Seminar and psychosomatic medicine regional meeting, University of Florida College of Medicine, Gainesville.

Books

The New Way to Live with Diabetes: A Complete Guide. By Charles Weller, M.D. and Brian Richard Boylan. Illustrated. Price \$3.95. New York, Doubleday & Company, Inc., 1966.

Atlas of Hernia Repair. By Carl H. Calman, M.D., F.A.C.S. Pp. 159. Illustrated. Price \$16.75. St. Louis, The C. V. Mosby Company, 1966.

Current Practice in Orthopaedic Surgery. Edited by John P. Adams, M.D. Pp. 276. Illustrated. Vol. 3. Price \$18.75. St. Louis, The C. V. Mosby Company, 1966.

Surgical Diseases of the Chest. Edited by Brian Blades, M.D. Pp. 687. Illus. 295. Second edition. Price \$25.00. St. Louis, The C. V. Mosby Company, 1966.

Letters



Editor's Note: The letter which follows accompanied the Christmas editorial written by the Rev. Donis D. Patterson appearing on page 1197 of this issue. This is such a warm expression of feeling toward the medical profession that we wish to share it with our physician readers. All of us are grateful and honored that Fr. Patterson has contributed this timely and eloquent thought to us.

T. M.

October 29, 1966

Dear Editor:

Enclosed please find my completed manuscript for the guest editorial to be included in the December issue of the Journal of the Florida Medical Association. It is my sincere hope that I have written along the lines which you envisioned for such an article and that the writing will be of help.

At this time I want to thank you for inviting me to participate in this work. Having been a "fan" of your association for such a good while, and having such a splendid membership of members in your profession associated with Saint Mark's Parish, I can truthfully tell you two things at this time. One is that I have never felt more highly honored. The other is that I have never felt quite so inadequate.

God bless you, the Journal, and the association in all your works. I pray that I may have been of some help and that you will call upon me at any time for anything which I may do in behalf of your work.

THE REV. DONIS D. PATTERSON, RECTOR
SAINT MARK'S EPISCOPAL CHURCH
VENICE

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secure
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against
pregnancy

Massive, worldwide
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Weight gain as infrequent
as weight loss

New freedom from
undesirable effects

New low cost

Contraindications—Mammary or genital carcinoma should be ruled out prior to administering Ovulen. Undiagnosed vaginal bleeding is also a contraindication to Ovulen use. A history of thrombophlebitis or pulmonary embolism, or both, is a contraindication to the use of Ovulen, unless its use is judged by the physician to be necessary despite the possible risk. Ovulen should not be used in women with suspected or overt liver dysfunction or disease. Ovulen is contraindicated in pregnant and nursing women and in patients with a history of cerebrovascular accident.

Warnings—Medication should be discontinued pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. Medication should be withdrawn if examination reveals papilledema or retinovascular lesions. Since the safety of Ovulen therapy in pregnancy has not yet been established, it is recommended that, in a patient who has missed two consecutive menstrual periods, pregnancy be ruled out before oral contraceptive therapy is continued.

Precautions—Because Ovulen may aggravate a tendency toward fluid retention in some patients, it should be administered cautiously to patients with a history of renal or cardiovascular disease (including hypertension), asthma, epilepsy or migraine. Any possible influence of long-term Ovulen therapy on pituitary, adrenal cortical, ovarian, hepatic or uterine functions requires further study. Oral contraceptives also should be administered cautiously to diabetic patients since a decrease in glucose tolerance has been observed in some patients taking these drugs. Patients on Ovulen may occasionally show abnormal glucose tolerance tests, but this does not necessarily indicate the presence of diabetes. Significant increases in platelet count, prothrombin and proconvertin tests, plasma thrombotic activity and plasma proteolytic activity have been reported.

Since estrogens may affect results of serum protein bound iodine and other thyroid function tests, these tests should not be considered definitive until Ovulen therapy has been discontinued for at least sixty days. Adrenal steroid serum levels and excretion may be affected by estrogens; the Metopirone® (SU-4885) test of pituitary-adrenal function may also be depressed. Abnormalities in hepatic function tests have also been reported, including some interference with dye excretion by the liver. This interference may give rise to Bromsulphalein® retention and jaundice in susceptible individuals. Serious liver dysfunction should be ruled out before continuing Ovulen administration when abnormalities in liver function tests occur.

Patients with a history of psychic depression should be observed carefully during treatment with oral contraceptives, and such treatment should be discontinued if depression recurs to a serious degree. Pre-existing fibroids may increase in size during Ovulen therapy. Such fibroids may regress to pretreatment size after Ovulen is stopped. In the event of breakthrough bleeding the possibility of nonfunctional causes should be borne in mind. Additional means of contraception should be used during the first seven days of Ovulen administration in the first treated cycle, because early ovulation may possibly occur.

Side Actions—The following adverse reactions have been reported with Ovulen; however, a causal relationship to Ovulen administration has not been established in all of the listed complaints: headache, dizziness, depression, breast complaints, amenorrhea, chloasma, vomiting, allergy, edema, migraine, pulmonary embolism, thrombophlebitis, visual difficulties, nervousness, rash, itching, decrease in libido, tiredness, malaise, hair loss and hair growth. A small incidence of nausea, spotting and breakthrough bleeding has been reported; these complaints tend to diminish markedly or disappear after the first cycle of treatment. Some of these side actions have required discontinuation of the drug.

Dosage—One tablet daily for 20 consecutive days beginning 5 days after the onset of menstruation.

Before prescribing see Detailed Product Information, Ovulen.
An extensive list of references on Ovulen is included in the literature mailed to physicians.

Research in the Service of Medicine
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SEARLE

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1mg. Each tablet contains:
ethynodiol diacetate 1 mg.
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effective contraceptive available



why wonder about a drug when you know

DECLOMYCIN[®] **DEMETHYLCHLORTETRACYCLINE**

is effective b.i.d.



It's made for b.i.d.

Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive.

Contraindication—History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort.

Precautions and Side Effects—Overgrowth of nonsusceptible organisms may occur. Constant observation is essen-

tial. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

Capsules: 150 mg; **Tablets:** film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

Everyone says she's a barrel of fun



But what does she think?



Many overweight patients can benefit from the appetite control provided by the sustained anorexigenic-tranquilizing action of BAMADex SEQUELS: anorexigenic action of amphetamine; tranquilizing action of meprobamate; prolonged action through sustained release of active ingredients.

Bamadex® Sequels®

DEXTRO-AMPHETAMINE SULFATE (15 mg.) SUSTAINED RELEASE CAPSULES
WITH MEPROBAMATE (300 mg.)

**to help establish
a new dietary pattern**

Contraindications: Dextro-amphetamine sulfate: in hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdose may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.



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Deaths

Anderson, Arnold S., St. Petersburg; born in Milan, Minn., Aug. 20, 1898; University of Minnesota Medical School, Minneapolis, Minn., 1925; served an internship at the Northern Pacific Railroad Hospital, St. Paul, Minn., 1925; served as a private in the infantry during World War I; was an instructor in chest diseases at the University of Minnesota, 1926-1931; came to St. Petersburg in 1932 to practice internal medicine; helped establish various state tuberculosis hospitals, was a former medical adviser and a member of the Florida State Tuberculosis Board and helped organize an Emphysema Research Association in St. Petersburg; was a fellow of the American College of Physicians; was Past Regent, International College of Chest Physicians; was a member of the Phi Rho Sigma Medical Fraternity and the American Medical Association; died August 30, aged 68.

Cowell, Edward Huntington, Coral Gables; born in Pennsylvania, Aug. 29, 1899; University of Pennsylvania School of Medicine, Philadelphia, 1924; interned at Pennsylvania Hospital for two years, served a residency at St. Lukes Hospital, New York City, and completed his postgraduate studies at the University of Vienna; engaged in the practice of ophthalmology in Ithaca, N. Y. for 14 years prior to locating in Coral Gables; held membership in the American Medical Association, Southern Medical Association, American Academy of Ophthalmology and Otolaryngology and Florida Society of Ophthalmology and Otolaryngology; died August 5, aged 67.

Crisler, George Russell, Winter Park; born in Normal, Ill., Feb. 27, 1902; University of Chicago, The School of Medicine, 1931; served as an instructor and associate professor of physiology at the University of Chicago, University of Missouri and University of West Virginia from 1926 to 1935; was a fellow at the Mayo Clinic, Rochester, Minn. from 1936 to 1937; came to Winter Park in 1938, establishing himself in the private practice of medicine; was a Flight Surgeon with the U.S. Air Force from 1942 to 1946; was

vice president of the Central Florida Mental Health Association and an internist on the medical advisory committee of the Orange County Tuberculosis and Health Association; was a member of the American Medical Association, Aviation Medicine, American College of Physicians, American Geriatrics Association, American Gerontological Society, American Heart Association and American Physiological Society; died September 27, aged 64.

Fessenden, Clarence Leon, Winter Park; born in Syracuse, N. Y., Dec. 20, 1888; Syracuse University College of Medicine, 1910; engaged in the general practice of medicine in Fulton, N. Y. for 18 years before going to Kings Park State Hospital, Long Island, N. Y., where he served a residency and rose to assistant director; retired from Kings Park Hospital in 1953, came to Florida, passed the state medical board examinations at age 63, and engaged in the private practice of psychiatry in Winter Park; licensed to practice in almost every state, he held membership in the American Medical Association and was a diplomate of the American Board of Psychiatry; died September 27, aged 77.

Flipse, Robert Charles, Miami; born in Minneola, N. Y., Nov. 3, 1924; New York Medical College, New York City, 1948; interned at Queens General Hospital, in that city, 1948-1950 and served residencies at U. S. Naval Hospital, St. Albans, N. Y., 1950-1951, Lenox Hill Hospital, N. Y., 1952-1954 and Long Island Memorial Hospital for Cancer and Allied Diseases, N. Y., 1954-1955; served in the U. S. Naval Reserve Hospital Corps as an enlisted man during World War II and in the Naval Reserve Medical Corps, where he attained the rank of lieutenant commander; was decorated for service in various foreign theaters and service in the Occupation Forces, Mediterranean Fleet; came to Miami in 1955 as a radiologist with Jackson Memorial Hospital; held membership in the American College of Radiology, Radiological Society of North America, Society of Nuclear Medicine, American Malacological Union, American Heart Association, Association

for Tropical Biology, Florida Radiological Society, Greater Miami Radiological Society and Aesculapian Society of Miami; was a fellow of the International Oceanographic Foundation; died October 9, aged 41.

Jones, Carroll Byrd, New Smyrna Beach; born in Santa Barbara, Brazil, Apr. 17, 1900; Vanderbilt University School of Medicine, Nashville, Tenn., 1928; interned at the Duval Medical Center, Jacksonville, 1928-1929 and served a residency at the University of Florida Infirmary, Gainesville, 1930-1931; served in the U. S. Naval Medical Corps Reserve from 1936 to 1948, attaining the rank of commander; came to New Smyrna Beach in 1931 and engaged in the general practice of medicine; served as a city commissioner of New Smyrna Beach from 1950 to 1956 and served two terms as mayor of that city from 1951 to 1954; held membership in the American Medical Association; died October 7, aged 66.

Parvey, Arthur Irving, Jacksonville; born in Boston, 1918; Tufts University School of Medicine, Boston, 1944; served an internship and residencies in surgery, gynecology and obstetrics, 1945-1956, in Boston and New York City; served in the Army Medical Corps Reserve, attaining the rank of major; was chief of the department of obstetrics and gynecology, Station Hospital, Third Army Headquarters, Fort McPherson, Atlanta, Ga., 1955, and assistant to the chief in obstetrics and gynecology, U. S. Army Hospital, Fort Jackson, S. C., 1954-1956; came to Jacksonville in 1957 to practice obstetrics, gynecology and surgery; was a member of the American Medical Association, American College of Surgeons, and National Board of Obstetrics and Gynecology; died August 23, aged 47.

Waas, Frederick James, Jacksonville; born in Fernandina, June 27, 1881; University of Maryland School of Medicine, Baltimore, 1905; returned to Fernandina in 1905 and practiced medicine there for four years before moving to Jacksonville; entered the medical department of the United States Army in 1918, was commissioned as a captain and stationed at the base hospital, Camp Wheeler, Georgia, where he served until after the signing of the armistice; served as the president of the Duval County Medical Society in 1918, as chairman of the Florida Medical Association Scientific Program Committee in 1925, as first vice president of the Florida Medical Association in

1926 and as President of the Florida Medical Association in 1928; was chief of the surgical department, St. Lukes Hospital, Jacksonville, associate head of the surgical department and secretary of the staff at St. Vincent's Hospital, Jacksonville and associate in gynecology at the Duval County Hospital, Jacksonville; for many years served as local surgeon of the Seaboard Airline Railway, resigning this position in 1926; held membership in the American Medical Association and Southern Medical Association, and was a fellow of the American College of Surgeons; died October 15 after an extended illness, aged 85.

Whaley, Fred Eugene, St. Petersburg; born in Sevier County, Tenn., Sept. 4, 1906; University of Tennessee College of Medicine, Memphis, 1937; served an internship at Tampa General Hospital, 1937-1938, and a residency at Mound Park Hospital, St. Petersburg 1938-1939; since 1939 had engaged in the general practice of medicine in St. Petersburg; was a flight surgeon for a service command unit at Ft. MacArthur, San Pedro, Calif., during World War II and was later transferred to Hickam Field, Honolulu, where he was chief of medicine before being reassigned as base surgeon at Kwajalein in the Marshall Islands; was elected president of the Sunshine Rifle and Pistol Club, St. Petersburg, 1966; was a member of the American Medical Association; died September 13, aged 60.

Wood, Alvin James, St. Petersburg; born in Carthage, Mo., May 22, 1882; American Medical Missionary College, Battle Creek, Mich., 1910; served in the Army Medical Corps during World War I; came to St. Petersburg to practice internal medicine in 1913; president of the Pinellas County Medical Society in 1919; chief of staff, Mound Park Hospital, St. Petersburg, 1928, and chief of the medical staff for many years; was one of the founders of St. Petersburg Federal Savings and Loan Association in 1939 and served as its president from 1951 to 1960; was a member of Christ Methodist Church board of trustees for 40 years and president of the board for 35 years; was president of the St. Petersburg YWCA during its building and was chairman of its board of trustees for many years; was a charter member of the St. Petersburg Kiwanis Club; held membership in the American Medical Association; retired in 1960 at the age of 78; died August 5, aged 84.

Schedule of Meetings

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association.....	George S. Palmer, Tallahassee.....	Floyd K. Hurt, Jacksonville.....	Bal Harbour, May 11-14, 1967
Florida Specialty Societies			
Allergy Society.....	Woods A. Howard, Lakeland.....	Robert J. Brennan, Ft. Laud'dale.....	
Anesthesiologists, Soc. of.....	John A. Rush Jr., Jacksonville.....	Richard C. Hartsfield, Jacksonville.....	
Chest Phys., Am. Coll., Fla. Chap.....	Franklin G. Norris, Orlando.....	Howard M. DuBose, Lakeland.....	
Dermatology, Society of.....	Arthur Appleyard Jr., St. P'burg.....	William W. Bruce, Winter Park.....	
General Practice, Academy.....	Louis C. Murray, Orlando.....	William P. Clarke, Jacksonville.....	
Internal Medicine.....	Addison L. Messer, St. P'burg.....	Abbott Y. Wilcox Jr., St. P'burg.....	
Neurosurgical Society.....	James F. Cooney, W. Palm Beach.....	Jack W. Barrett, Miami.....	
Obst. & Gynec. Society.....	William T. Mixson Jr., Coral Gbls.....	Joseph W. Pilkington, St. P'burg.....	
Ophthalmology Society.....	Younger A. Staton, W. Palm Beach.....	Charles F. McCrory, Jacksonville.....	
Orthopedic Society.....	William J. Hutchison, Tallahassee.....	Robert J. Pfaff, Lakeland.....	
Otolaryngology Society.....	M. A. Schofman, Miami.....	West Bitzer, Ocala.....	
Pathologists, Society of.....	Jerome Benson, Miami Beach.....	Marcus J. Zbar, Ft. Lauderdale.....	
Pediatric Society.....	James M. Weaver, Ft. Lauderdale.....	Ray O. Edwards Jr., Jacksonville.....	
Phys. Med. & Rehab., Fla. Soc.....	Sterling H. Huntington, C'l Gbls.....	Bruce B. Sutton, Coral Gables.....	
Plastic & Reconstr. Surg.....	James G. Robertson, Miami.....	Robert L. Wells, St. Petersburg.....	
Preventive Medicine, Fla. Soc.....	Joseph W. Lawrence, Ft. Myers.....	E. Charlton Prather, Orange Park.....	
Proctologic Society.....	Richard I. Brashear, Naples.....	John T. McCormick, Jacksonville.....	
Psychiatric Society.....	W. Laney Whitehurst, Jacksonville.....	Moke W. Williams, Ft. Lauderdale.....	
Radiological Society.....	Andre S. Capi, Ft. Lauderdale.....	Malcolm S. Van de Water, P'm B'h.....	
Surgeons, Am. Coll., Fla. Chap.....	A. T. Kennedy, Pensacola.....	Harry W. Reinstine Jr., Jack'ville.....	
Surgeons, Gen., Fla. Assn.....	Thad Moseley, Jacksonville.....	Jesse W. Castleberry, Orlando.....	
Surgeons, Int. Coll., Fla. Chap.....	Leo H. Wilson Jr., Sarasota.....	Wendell J. Newcomb, Pensacola.....	
Urological Society.....	Robert N. Webster, Tallahassee.....	Miles W. Thomley, Orlando.....	
FLORIDA			
American Cancer Society, Div.....	Donald W. Smith, Miami.....	Mrs. Peggy Lombardo, J'ville.....	November 1967
Arthritis Foundation, Chap.....	Mr. Ernest R. Currie, Dayt'a B'ch.....	Mrs. Barbara White, Gainesville.....	Jacksonville, May 1967
Basic Science Examining Board.....	Paul A. Vestal, Ph.D., Winter Park.....	Theodore A. Ashford, Ph.D., 1832 Bearss Ave., Tampa 33612.....	Coral Gables, June 3, '67
Blood Banks, Association.....	Alfred L. Lewis Jr., Tallahassee.....	Mrs. Betty Sawyer, Tallahassee.....	Sarasota, April 1967
Blue Shield of Florida, Inc.....	W. Dean Steward, Orlando.....	John T. Stage, Jacksonville.....	
		Mr. H. A. Schroder, Ex. Dir., P. O. Box 1798, J'ville 32201.....	Bal Harbour, May 11-14, '67
Crippled Children & Adults, Soc.....	Mr. Bruce Thomason, Gainesville.....	Mrs. Page Hufty, Palm Beach.....	Miami, Fall of 1967
Diabetes Association.....	Matthew E. Morrow, Jacksonville.....	Robert T. Rengarts, Sebring.....	Miami Beach, Sept. 28-30, '67
Heart Association.....	Donald E. Warren, W. Palm Beach.....	Mr. Philip F. Ashler, Pensacola.....	Jacksonville, May 20-21, '67
Medical Examining Board.....	J. Scottie Wilson, Ft. Lauderdale.....	Leo Grossman, Miami.....	
		Homer L. Pearson Jr., Ex. Dir., P.O. Box 5, Biscayne Annex, Miami 33152.....	Jacksonville, Jan. 15-17, '67
Mental Health, Association for.....	Mrs. Richard F. Stover, Miami.....	Mrs. Alfred Koenig, St. Petersburg.....	Ft. Lauderdale, Apr. 20-22, '67
National Foundation.....	Mr. Basil O'Connor, New York.....	Mr. Ed Foreman, Orlando.....	April 1967
Nat'l Multiple Sclerosis Soc.....	Mr. Harold W. Comfort, N. York.....	Mr. Robert E. McWeeney, H'vw'd.....	Minneapolis, Minn., Oct. 7, '67
Prevention of Blindness, Soc. for.....	Mr. R. B. Matthews, Coral Gables.....	Mrs. Richard Nosti, Tampa.....	Jacksonville, Nov. 18, '67
Public Health Association.....	William R. Stinger, Miami.....	Mrs. Margaret McLendon, J'ville.....	Miami Beach, Oct. 22-26, '67
Retarded Children, Association for.....	Mrs. G. F. Ward, Avon Park.....	Mrs. J. M. Riedel, Cocoa.....	Ft. Lauderdale, May 5-7, '67
Thoracic Society.....	L. H. Kingsbury, Orlando.....	T. S. Feng, W. Palm Beach.....	Hollywood, Apr. 27-29, '67
Tuberculosis & Res. Dis. Assn.....	Mr. Tom Coldewey, Port St. Joe.....	Mr. J. C. Inman, Orlando.....	Hollywood, Apr. 27-29, '67
United Cerebral Palsy of Florida.....	John P. Hilburn, Tampa.....	Harry Botwick, Miami.....	November 1967
Woman's Auxiliary.....	Mrs. Allen E. Kuester, Cocoa.....		Bal Harbour, May 11-14, '67
American Medical Association.....	Charles L. Hudson, Cleveland.....	Mrs. Linus W. Hewit, Tampa.....	Atlantic City, June 18-22, '67
A.M.A. Clinical Session.....		F. J. L. Blasingame, Chicago.....	Houston, Nov. 26-29, '67

(Most Specialty Group meetings are scheduled at the time of the annual meeting of the Association)

County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	TOTAL MEMBERS Associate Active
Alachua	Robert L. Williams, Gainesville	Taylor H. Kirby Jr., Gainesville	2nd Tues.	32
*Bradford, Gilchrist, Union Bay	William C. Fontaine, Panama City	Paul A. Johnson, Panama City	1st Tues.	0
Brevard	Adrian R. Jensen, Rockledge	Donald M. Bryan, Cocoa	1st Tues.	40
Broward	Ray E. Murphy Jr., Pompano Beach	Theodore W. Hahn, Pompano Beach	4th Tues.	146
Charlotte	Fred Paul Nisi, Port Charlotte	Carl N. Reilly, Punta Gorda	2nd Tues.	50
Clay	William A. Mulford, Gr. Cove Spgs.	Aubrey Y. Covington, Gr. Cove Spgs.	2nd Tues.	11
Collier	Bruce Boynton II, Naples	Ethel H. Trygstad, Naples	3rd Wed.	10
Columbia	John T. Wilson, Lake City	Charles T. Ozaki, Lake City	3rd Wed.	1
Dade	William M. Straight, Miami	H. Clinton Davis, Miami	1st Tues.	15
DeSoto-Hardee-Glades	Gordon H. McSwain, Arcadia	Calvin W. Martin, Arcadia	1st Tues.	193
Duval	Wade S. Rizk, Jacksonville	Herbert A. Burke Jr., Jacksonville	1st Tues.	2
Escambia	Joseph Q. Perry, Pensacola	William R. Bell, Pensacola	2nd Tues.	49
Franklin-Gulf	Harold B. Canning, Wewahitchka	Photis J. Nichols, Apalachicola	1st Tues.	2
Gadsden-Liberty	Hilliard R. Reddick, Quincy	George H. Massey, Quincy	Last Wed.	1
Highlands	Donald C. Hartwell, Avon Park	Walter M. Ost, Avon Park	Quarterly	4
Hillsborough	James A. Winslow Jr., Tampa	Frank A. Massari, Tampa	3rd Mon.	0
Indian River	William R. White, Vero Beach	Hampton L. Schofield Jr., Vero Beach	1st Tues.	7
Jackson-Calhoun	Glenn E. Padgett, Marianna	Francis M. Watson, Marianna	2nd Tues.	0
Lake	Geoffrey H. Binnevelt, Leesburg	C. Robert Crow, Mt. Dora	Quarterly	0
Lee-Hendry	Charles C. Donegan Jr., Ft. Myers	Edward W. Salko, Ft. Myers	1st Wed.	2
Leon-Wakulla-Jefferson	I. Barnett Harrison, Tallahassee	Alfred L. Lewis Jr., Tallahassee	3rd Mon.	4
Madison	William J. Bibb, Madison	Julian M. DuRant, Madison	1st Mon.	12
Manatee	Marvin Silver, Bradenton	James R. Kennedy, Bradenton	1st Tues.	1
Marion	Robert L. Gibson, Ocala	West Bitzer, Ocala	2nd Tues.	4
*Levy			3rd Tues.	6
Monroe	Herman K. Moore, Key West	Jose T. Sanchez Jr., Key West	1st Thurs.	2
Nassau	Cecil B. Brewton, Fernandina Beach	John B. Britton, Fernandina Beach	2nd Thurs.	4
*Baker				
Okaloosa	Henry I. Langston, Ft. Walton Beach	Frederick F. Crews, Ft. Walton Beach	1st Wed.	0
Orange	Harold W. Johnston, Orlando	Duane C. Deen, Orlando	3rd Wed.	47
*Osceola				
Palm Beach	Vernon B. Astler, W. Palm Beach	Bernard Kimmel, W. Palm Beach	4th Mon.	22
Fasco-Hernando-Citrus	W. Randall Jenkins, Inverness	W. Wardlaw Jones, Dade City	2nd Thurs.	6
*Sumter				
Pinellas	Abbott Y. Wilcox Jr., St. Petersburg	William H. Keeler III, St. Petersburg	1st Mon.	78
Polk	Edward C. Burns Jr., Lakeland	John P. Collins, Lakeland	2nd Tues.	13
Putnam	James C. Kitaif, Palatka	James R. Sayers, Palatka	2nd Wed.	1
St. Johns	Richard J. Langston, St. Augustine	Vernon A. Lockwood, St. Augustine	2nd Tues.	0
St. Lucie-Okeechobee-Martin	Martin G. Gould, Ft. Pierce	George Theodorou, Ft. Pierce	3rd Tues.	20
Santa Rosa	Elbert W. Sutton, Milton	Claude J. Barnes, Milton	3rd Thurs.	47
Sarasota	Irving A. Beychok, Sarasota	William J. Jenkins, Sarasota	2nd Thurs.	4
Seminole	Robert J. Smith, Sanford	John T. Johnson, Sanford	2nd Tues.	17
Suwannee-Hamilton-Lafayette	Frederick T. Mickler Jr., Jasper	James F. Dietrich, Live Oak	1st Sat.	0
Taylor	James A. Rawls Jr., Perry	John A. Dyal Jr., Perry	Last Fri.	6
*Dixie				
Volusia	Michael R. Blais, Daytona Beach	Thomas D. Cook, Daytona Beach	2nd Tues.	8
*Flagler				
Walton	Howard F. Currie, DeFuniak Springs		3rd Tues.	0
Washington-Holmes	John T. Grace, Bonifay	James B. Craven, Chipley	Quarterly	7
				4
Total				578
Grand Total				5,000
				5,578

Classified Advertisements

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physicians wanted

General Practitioners

GENERAL PRACTITIONER OF INTERNIST: for association with mixed group. Salary plus percentage and all expenses. Share coverage on days off, weekends, vacations. Guarantee \$20,000 first year. Contact T. C. Kenaston Jr., M.D., Box 550, Cocoa 32922, phone (305) 636-4221.

GENERAL PRACTITIONER WANTED (AAGP) for north Florida college town. Vacancy in busy two man practice in medicine, pediatrics and obstetrics. Immediate excellent income with eventual full partnership. Write C-614, P.O. Box 2411, Jacksonville, Fla. 32203.

GENERAL PRACTITIONER WANTED: Orlando, Orange County, East Central. Florida license required. Full time opening in county-supported medical clinic. Contact B. S. Webster, M.D., Medical Director, Orange County Medical Clinic, 832 W. Central Ave., Orlando 32805. Phone 241-4311, ext. 364.

GENERAL PRACTITIONER OR INTERNIST: Medical offices available November 1. One to four doctors accommodated. Modern structure with many medical facilities among tenants. Heart of Winter Park, Florida. Telephone: 644-8217. Write: c/o 240 New England Building.

EXCELLENT OPPORTUNITY for general practitioner in community of 15,000; central Florida; 76 bed JCAH hospital. Write or call collect R. C. Thompson, Bartow Memorial Hospital, Bartow, Fla.

GENERAL PRACTITIONER wanted for association with established young G.P. or to rent excellent office space in growing community. New hospital under construction nearby. Write G. L. Ehringer, M.D., 1370 Ocean Shore Blvd., Ormond Beach, Fla. or phone 677-2902.

PEDIATRICIAN wanted for association with two obstetricians. Office space, basic equipment and guaranteed income are available for an acceptable man. Write C-551, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: General practitioner associate, leading to partnership. Practice approximately one half industrial. Ideal central Florida community. Send detailed resume to C-716, P.O. Box 2411, Jacksonville, Fla. 32203.

GENERAL PRACTITIONER wanted for Coral Gables Medical Clinic. Established practice. Everything furnished—percentage basis. Write C-726, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: General practitioner for north Florida beach resort city. Rapid growth. Facilities and other generous financial incentives offered. Write P.O. Box 9190, Panama City Beach, Florida 32401.

GENERAL PRACTITIONERS OR PSYCHIATRISTS interested in psychiatry. Veterans Administration Hospital, Tuscaloosa, Alabama. Salaries to \$19,000 based on training and experience. Liberal retirement plan, 30 days vacation with pay, 15 days sick leave per year, health and life insurance programs. Opportunity for physicians interested in regular hours with less demanding duties than private practice. Write Chief of Staff (11), VA Hospital, Tuscaloosa, Ala. 35401. An Equal Opportunity Employer.

Specialists

PEDIATRICIAN: Board eligible, to join two board pediatricians in rapidly growing Southeastern Florida coastal college town. Early partnership anticipated, excellent hospitals nearby. Send references and curriculum vitae in first letter. C-719, P.O. Box 2411, Jacksonville, Fla. 32203.

PEDIATRICIAN: Florida Southeast coast. Well qualified pediatrician for association with group of two pediatricians. Suburb of Palm Beach, Florida. Excellent opportunity for well qualified man in an excellent living area. Write D. R. Bicknell, M.D., Professional Building, North Palm Beach, Florida 33403.

OBSTETRICIAN-GYNECOLOGIST WANTED: To associate with two man group. Large established practice in Miami; Board eligible or certified; prefer under age 35. Write P.O. Box 384, Miami Shores, Fla. 33153.

OPENING IN INTERNAL MEDICINE in 15 man group with four in internal medicine. Guarantee first year, partnership in 2 to 3 years. Write to John E. Bechtold, M.D., Palm Beach Medical Group, P.O. Box 2068, West Palm Beach, Fla. 33402.

WANTED: Cuban trained pediatrician who speaks English and Spanish as an associate. Partnership in one year. \$14,000 first year. Must have had 3 years intern-residency training in U.S.A. and be board eligible. Write William L. Rumsey, M.D., 1336 North Avenue, Elizabeth, New Jersey 07208.

WANTED: Board eligible general surgeon under age 40 for association with two general surgeons in greater Miami area. Florida license required. Write C-699, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: Doctor, internal medicine preferred, for Rainbow Lakes Estates. Community mostly retirees, Marion County, Florida. Offer: air-conditioned office space rent free and utilities furnished for two years; house available. Three hospitals radius 30 miles. Ambulance service available. Write to Joseph D. Stearns, Route 2-A, Box 66, Dunnellon, Florida.

PEDIATRICIAN drafted in West Palm Beach area. Fully equipped office and full practice. Looking for young pediatrician to take over. Write C-724, P.O. Box 2411, Jacksonville, Fla. 32203.

OBSTETRICIAN-GYNECOLOGIST, board eligible or certified, to join two diplomates in private practice, Miami, Florida. Medical school appointment available. Salary first year, early partnership. Send resume. Write C-725, P.O. Box 2411, Jacksonville, Fla. 32203.

INTERNIST WANTED: Older board internist wants young associate, either board certified or eligible. Write F. D. Pierce, M.D., 509 Isle of Palms, Ft. Lauderdale, Florida 33301.

WANTED: Board or board eligible internist with Florida license to take over busy practice of disabled internist in eight man group on West coast of Florida. Write C-721, P.O. Box 2411, Jacksonville, Fla. 32203.

Miscellaneous

STUDENT HEALTH PHYSICIANS: Openings July 1967, for active, young general practitioners, internists or pediatricians interested in adolescents. Comprehensive student health service directed toward modern community health program. Affiliated with major University Medical Center in Southeast. Opportunity for teaching, research and faculty status if qualified. Compensation to \$17,000 with benefits. One immediate appointment available at \$14,625. Enclose full resume with first correspondence. Write C-722, P.O. Box 2411, Jacksonville, Fla. 32203.

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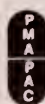
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Chest Pain: a somatic mask of psychic tension?

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"Heart symptoms"—chest pain, tachycardia, arrhythmia—invariably alarm and preoccupy the patient, though they may be completely without organic basis. Such symptoms often are somatic masks of psychic tension, arising from constant encounters with stressful situations.

When the problem is diagnosed as emotionally produced, consider Valium (diazepam) as adjunctive therapy. Valium (diazepam) acts rapidly to calm the patient, to reduce his psychic tension and relieve associated cardiovascular complaints.

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Valium (diazepam) is generally well tolerated, and usually does not impair mental acuity or ability to function. If side effects such as ataxia and drowsiness occur, they usually disappear with dosage adjustment.

Contraindications: Infants, patients with history of convulsive disorders or glaucoma.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly patients (not more than 1 mg, one or two times daily) to preclude ataxia or oversedation. Advise patients against possibly hazard-

ous procedures until correct maintenance dosage is established; driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. Warn patients of possible combined effects with alcohol. Safe use in pregnancy not established. Observe usual precautions in impaired renal or hepatic function and in patients who may be suicidal; periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances and hallucinations) and changes in EEG patterns. Abrupt cessation after prolonged over-dosage may produce withdrawal symptoms similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Dosage — Adults: Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hrs, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. Geriatric patients: 1 or 2 mg/day initially, increase gradually as needed.

Supplied: Tablets, 2 mg, 5 mg and 10 mg; bottles of 50 for convenience and economy in prescribing.

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